Health and Social Care

insight solutions

Stakeholder Engagement on the Public Health Agency's Planned Re-Procurement of Alcohol & Drug Services

January 2021

Contents

1.0 Introduction

The Public Health Agency (PHA) commissioned Insight Solutions to facilitate a period of stakeholder engagement to help inform decisions around the commissioning requirements and priorities for drugs and alcohol services to be provided under PHA contracts in the future.

The purpose of this stakeholder engagement was to help the PHA:

- 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 priorities can be agreed for the next 4-7 years;
- Gain a deeper understanding of the various needs and interests of those who will be directly and indirectly affected by funded services.

Alongside this stakeholder engagement exercise the PHA also carried out additional stakeholder engagement with the regional Health and Social Care Board / Health and Social Trusts' (HSCT) Tier 3 & 4 Addictions Group, with the focus on specific services included in the planned procurement process. A presentation of themes from this period of stakeholder engagement will also be presented within this report (Section 3.5).

1.1 Work to Date

This stakeholder engagement builds on previous engagement undertaken in 2012/13 to inform the development of the Regional Health and Social Care Alcohol and Drug Commissioning Framework for Northern Ireland (2013 – 2016). This framework outlined the key prevalence figures of alcohol and drug related harm in Northern Ireland and brought together the evidence base in relation to what is effective in tackling these issues. It also sought to inform organisations within and beyond the HSC who are involved in commissioning services to address the issue of alcohol and drug misuse. Furthermore, it provided information on the commissioning requirements and priorities for commissioners within the PHA / Health and Social Care Board (HSCB). The purpose of the Framework was to deliver on the following outcomes:

- Improved consistency of service provision across the five HSCT areas;
- Improved understanding of what works, and the commissioning of services better informed by evidence-based practice;
- A reformed and modernised service provision;
- Integration of PHA and HSCB commissioning plans and priorities.

1.2 Future Work/Next Steps

This Report represents and reflects a very extensive stakeholder engagement and consultation process that inevitably means that there are a number of critical issues raised that need to be carefully reviewed. The PHA will consequently consider the issues raised through the Report in the wider context of key factors that impact on procurement processes and planning. This includes performance reviews of existing tendered services, evidence reviews, needs data, priorities reflecting strategic and policy context and legal considerations. The PHA will communicate to key stakeholders the subsequent decisions made on consequent procurement and related timescales.

2.0 Methodology

2.1 Engagement Approach

Whilst the original methodology was to facilitate face-to-face sessions, this was not possible due to restrictions associated with COVID-19. To ensure safety and ease of access, sessions were carried out using Zoom online meeting software.

Engagement events were widely advertised via PHA website and through relevant stakeholder networks. A dedicated session was held with Regional Service User Network (RSUN) members. Two sessions per Health Trust were held, with one focusing on young people and community services and another on adult services. Attendance at these sessions ranged from staff from currently commissioned organisations, other community and voluntary organisations and statutory bodies.

An online survey was available for stakeholders to provide their views in a written form. This survey remained open for two weeks following the final stakeholder engagement event to allow time for attendees or those who had been unable to attend digital events to add further comment.

Table 1 provides an outline of the stakeholder engagement process and the levels of engagement.

Date	Trust Area	Focus	Number of Participants (per session)	Number of Organisations Represented (per session)
Monday 12th October 2020	Regional Service Users Network (NI Wide)	N/A	14	N/A
Thursday 15th October 2020	Northern Health and Social Care Trust	Young People/ Community Services	12	6
		Adult Services	16	7
Wednesday 21st October 2020	South Eastern Health and Social Care Trust	Adult Services	20	12
		Young People/ Community Services	21	14
Tuesday 27th October 2020	Belfast Health and Social Care Trust	Young People/ Community Services	23	15
		Adult Services	45	29
Thursday 5th November 2020	Western Health and Social Care Trust	Adult Services	17	12
		Young People/ Community Services	18	11
Wednesday 11th November 2020	Southern Health and Social Care Trust	Young People/ Community Services	21	15
		Adult Services	23	12
		OVERALL TOTAL	**216**	N/A

Table 1: Outline of Engagement Sessions

*** A further session was held with the regional HSCB / HSCT Tier 3 and 4 Additions Group on 25th November 2020, facilitated by Kathy Goumas, as instructed by PHA. This was outside of the contract awarded to Insight Solutions but has been included within this report as it had direct relevance.**

Table 2 provides a summary of the overall engagement, broken down by area/focus. It also includes the level of responses via the online survey.

Engagement	Total Attendees/ Respondents
Adult Services	121 attendees
Young People/Communities	95 attendees
Regional Service Users Network	14 attendees
Online Survey	40 responses

Table 2: Respondent Numbers

Table 3 provides a further breakdown of participation by sector/sub sector based on the ten sessions held across the five Health Trusts.

Sector	Number Represented at Stakeholder Engagement Sessions
NI Government Departments	2
Health and Social Care (Statutory)	7
Local Government	2
Other Statutory	6
Community & Voluntary Sector	34
Other	4

Table 3: Stakeholder Engagement Sessions – Participation by Sector

Please see Appendix 3 for further specific breakdown of stakeholders including organisations and sectors represented.

2.2 Approach

Stakeholder engagement events (for both Adult Services and Young People/Communities Services) followed the same approach, outlined in Table 4.

Step	Details
1	Insight Solutions provided an introduction to stakeholders, outlining the aims and objectives of the stakeholder engagement event.
2	PHA provided a presentation giving an overview of background and setting context.
3	Insight Solutions facilitated discussion with stakeholders focussing on: What has worked well in current service models? What gaps/ barriers exist? What links/connections need to be strengthened? What has not worked well in current service models?

Table 4: Approach

The conversations were intended to focus primarily on PHA commissioned services only, with conversations managed to ensure stakeholders' discussions were relevant and on topic. However, some issues understandably arose which brought conversations beyond the focus of only PHA commissioned services.

For reference, current PHA commissioned services are listed below. It is important to note that PHA do not fund Tier 3 or Tier 4 services. For a full understanding of current service providers within each Trust area, please refer to Appendix 4.

Children, Young People and Families:
- Step 2 community based Youth Treatment services (early intervention)
- Parental substance misuse (hidden harm therapeutic services)
- Targeted Prevention for Young People

Adults and the General Public:
- Step 2 community based Adult Treatment services (early intervention)
- Low Threshold Services (Outreach)

Capacity:
- Connections (Community Alcohol & Drugs Information and Networking services)
- Workforce Development programme

3.0 Findings

The themes presented represent stakeholder views which were expressed most frequently with the most consensus throughout the duration of the engagement period. A full capture of conversations can be reviewed in Appendix 1, alongside written survey responses.

Initially, themes which were common between discussions on Adult Services and Young People/Communities will be discussed. Following this, points which are specific to each respective service type and HSCT area will be outlined.

Please note that sections 3.1 and 3.2 and 3.3 cover services which are commissioned by PHA, with section 3.4 providing an outline of recurring themes which are not PHA commissioned but did feature prominently within the discussions.

In some cases, it is difficult to make clear distinctions between whether stakeholders were referring to PHA commissioned or wider HSC commissioned services, such are the inextricable links between them. Many stakeholders were clearly focused on the holistic service user journey and experience, rather than simply isolating what was a PHA commissioned service responsibility. It is important to note that input on services will also have varied due to varying degrees of knowledge and experience of services by stakeholders.

3.1 What Has Worked Well

On the whole, the key elements which stakeholders feel have worked well and value most within current service models are:

- **Strengthened Sector –** A key strength highlighted through engagement is the work which has been done to date within the Alcohol and Drugs subsector to build a strong, stable and resilient sub sector which is built on good practice and strong provision. Many stakeholders reflected on strong relationships which have been formed between service providers and users and amongst voluntary and community and with statutory service providers, as well as between service providers and PHA. There has also been the development of several forums and networks including the Northern Ireland Alcohol & Drugs Alliance (NIADA) which allow sharing of best practice and experience and which have contributed to enhancements and improvements within the area of Alcohol and Drugs. There is a significant level of mutual respect between stakeholders who value each other's role and contribution. Whilst there were some exceptions noted, there was general credit given for achieving a more consistent regional service across Northern Ireland.

- **Flexibility and Responsiveness –** Many stakeholders appreciated the ability to adapt to need/demand and work alongside the PHA to respond to change. This relates to flexibility of length/duration of service/intervention, and PHA's responsiveness to service providers when additional funds are required at times of heightened need. Stakeholders feel that this element must remain, and that flexibility must be retained so service users get support which is appropriate for them and not simply based on an arbitrary number of sessions etc. as an outcome. Many stakeholders note the importance of treatment being based on client outcomes with scope for a variety of interventions based on person-centred client needs.

- **Longer-term Contracts –** A number of stakeholders felt that contracts should remain at least a five-year minimum, with some expressing a desire for contracts up to 10 years. Some stakeholder felt that this ensured adequate time for professional development and upskilling of staff, a more embedded service and most importantly higher quality and consistent service provision.

- **Quality of Staff –** Service providers feel that staff are dedicated, knowledgeable and have built up vital relationships with service users. Stakeholders felt that it was imperative that this staff resource would not be lost with recommissioning of services.

- **Low Threshold Services Model –** Many stakeholders reflected on the low threshold services model and the ability for service users to be engaged where they are at.

- **Digital Appointments/Engagement –** Several stakeholders have noted what they considered a surprising uptake in online and telephone support appointments. Some stakeholders noted that appointment cancellations had been dramatically reduced. Whilst engagement using these methods was increased as a result of COVID-19, stakeholders feel it is important to make use of this method in any ongoing service. It must be noted, however, that impact of these services has not been formally reviewed or measured by PHA and impact/outcomes should be reviewed if this format is adopted in future commissioning models.

Stakeholders also noted advantages of service providers in some areas being able to make direct referrals into Step 3 services to enable users to access services quicker. Whilst not as a direct result of PHA commissioned services, it is included as a positive step forward.

3.2 Areas of Concern

3.2.1 Timing of Process

A number of stakeholders expressed concern that the stakeholder engagement on the PHA's planned re-procurement of alcohol & drug services should not have been carried out before consultation for the new Substance Use Strategy 'Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use'.

The PHA has been transparent and consistent in communicating that the stakeholder engagement and recommissioning is a legal requirement which was working to a specific timeframe. However, a number of key stakeholders reinforce the need for PHA commissioned services and Substance Use Strategy to have synergy and to ensure all commissioned services deliver on priorities outlined within the new Strategy.

On the whole, these stakeholders feel that in the best interests of service users and service delivery agents, the stakeholder engagement process in focus should have been postponed as the process may need to be repeated following release of the new Substance Use Strategy.

Further, concerns were expressed around the decision to carry out stakeholder engagement during the COVID-19 pandemic, with some stakeholders questioning use of resources and uncertainties around possible restraints of service delivery. In relation to COVID-19 and re-procurement, some stakeholders feel that the recommissioning timeline given by PHA will put additional pressure on service providers at a time when there is job uncertainty and increasing demand for services.

A number of stakeholders have suggested delaying procurement of PHA commissioned Drug and Alcohol services until the release of a new Strategy, allowing a comprehensive commissioning framework to be designed around the needs of service users.

Parallel to the stakeholder engagement sessions, a letter from the Northern Ireland Alcohol and Drug Alliance (NIADA), whose membership includes several PHA commissioned service providers (Addiction NI, ASCERT, DePaul Ireland, Dunlewey Addiction Services, Extern, Simon Community, Start360 and YMCA Lisburn etc.) expressing concern around the timing of this process can be found in Appendix 2, alongside similar concerns expressed in letters from Chairs of a number of local Drug and Alcohol Co-ordination Teams (DACTs).

A similar message was conveyed by stakeholders at the meeting of the regional HSCB / HSCT Tier 3 & 4 Addictions Group. The consensus from this forum was to delay the PHA procurement process in an effort to achieve greater alignment with the new Substance Use Strategy.

The Royal College of Psychiatrists have also expressed concern relevant to this matter. They cite a distinct lack of connectivity between how services are commissioned separately by PHA and HSCB, which *'do not support a planned whole systems approach'* (please see Appendix 1 for full response).

3.2.2 Demand for Services

The majority of stakeholders noted the rise in substance use and thus felt that demand for services is too great to be met by available services. For service providers this has led to pressure within their roles, and for service users it has resulted in longer waiting times and less ability to access services when they are needed and when motivation is high. Further to this, it has been noted that service users are presenting with increasingly complex issues and a rise in poly drug use leading to the need for more specific and tailored provision. Many stakeholders referred to complex issues which include, but are not limited to: social factors (financial, homelessness, childcare, housing) and mental health issues, discussed below.

3.2.3 Co-Occurring Substance Misuse and Mental Health

Perhaps the most prevalent, recurring concern throughout stakeholder engagement sessions was around co-occurring drug and alcohol misuse and mental health issues. Across the board, stakeholders noted that 'Dual Diagnosis' is an ever-growing concern which presents problems to both service users, providers and wider stakeholders. The complexity of service user needs is increasing, and stakeholders have called for a consistent, all-encompassing approach to respond to the complexity of needs that present with co-existing mental health and drug and alcohol misuse. Many stakeholders indicated that they felt there has been limited progress made towards a more collaborative approach and stated the need for:

- A more joined-up approach with Mental Health and Alcohol and Drug services working together to allow service users a holistic approach to treat substance misuse and mental health issues simultaneously;

- Easier access to and more advanced training for service providers/staff in dealing with dual-diagnosis – opportunities appear to be limited, expensive and help is needed in accessing and funding these;
- Easier access to services for service users – service users are often not meeting thresholds set by services which allow entry. For example, some mental health services use current substance use as exclusion criteria which is a barrier to assessment. This can create a 'revolving door' where people do not get the support where and when they need it;
- More appropriate and easier navigated referral pathways, particularly between Tier 2 and Tier 3, is required between Mental Health and Alcohol and Drugs services;
- Quick access to services for service users who need to receive support when motivation is high;
- Amalgamation (or at very least greater alignment) of Protect Life Implementation Groups (PLIGs) and Drug & Alcohol Co-Ordination Teams (DACTS) could be advantageous in bridging the gap;
- Better understanding that Mental Health and Alcohol and Drugs services will have overlap of service users and therefore joined up working could mean better use of resources and time.

This is an incredibly complex area and the stakeholder engagement process in itself highlighted varied understanding and interpretations of what it means. It also extends well beyond the remit of the PHA which does not commission Tier 3 services, but clearly is so significant that it needs to be captured and considered in the shaping of new services and strategic links made with other HSC services.

3.2.4 Referral Pathways

As alluded to in the above, referral pathways are considered as something which many stakeholders feel could be greatly improved. Clear and regionally consistent referral pathways are needed for all service users, irrespective of the support they need (i.e. drug and alcohol or mental health), with stakeholders stating the following:

- Different screening tools, referral processes and pathways used by statutory and community and voluntary sectors;
- Better experience for service provider and user when referrals can be made directly into a service;
- Service users with alcohol or drug issues should be co-located and have a single point of referral. Can often be a duplication of referrals across Tier 2 and 3 – single point of referral would enable individual referred to be directed to the most appropriate service at point of referral/prevent duplication of assessment process.
- Self-referral approach can work well;
- Needs to be a better approach to cross-Trust area referrals so that if a service user moves outside of one Trust to another Trust area their access to services does not have to start over;
- Referrals made via GPs can cause delays with long waiting lists. (It is unclear if stakeholders were referring to Tier 3 services in this matter, which are not funded by PHA);
- Referrals to Step 2 services are not adequately used by Primary Care;
- It was mentioned that in some cases, the volume of referrals and signposting from statutory services to PHA commissioned services is overwhelming and is putting pressure on service providers;
- Service users also need to be reassured that there is a smooth pathway/exit strategy out of a service to ensure transition into life independent of a service. This includes an exit strategy for low threshold services to allow a user to come back into service provision if required. Service users noted that this is vital in preventing relapse.

Relative to referral pathways and the need for a more consistent, coherent approach is the knowledge of services available. Many stakeholders feel that there must be better visibility of services, so statutory and community and voluntary organisations know who to refer to, or to enable service users to self-refer. Suggestions were made that this could be in the form of an online service map platform.

There does appear to be some confusion around the tiered system, specifically between Tier 2 & Tier 3 addiction services, which was described as 'somewhat arbitrary' by one representative body.

3.2.5 Collaborative Working/Joined-Up Approach

As also referred to earlier, a number of stakeholders felt a strong need for more collaborative and joined up working across the board. In some cases, there is clear progress in relationships within and between sectors, but blockages do remain. As well as taking into consideration the aforementioned need for mental health and drug and alcohol services to work more collaboratively, stakeholders considered the need for:

- Collaborative working between service providers in order to ensure awareness of services being accessed by service user. Particularly within young people's services, service users are facing duplication of services and being 'over-serviced'. Service providers considered it important that they were aware of the 'full picture' and that a joined-up approach was employed to ensure best outcomes for service users;

- A more collaborative approach between community and voluntary and statutory sector in working through the stepped process ensuring there is 'no wrong door' for service users;
- A more collaborative approach between wider Health sector and other important sectors such as the Education sector, Homeless sector, Social Services sector. The majority of stakeholders feel that joined up working requires a 'top down' rather than 'bottom up' approach – with statutory services needing to take the lead;
- Guidance or information on how information can be shared between services without breaching laws concerning confidentiality or GDPR regulations. Many stakeholders emphasised the need for the ability to share client information to ensure best provision for service user. This is currently problematic and impacting greatly on the service user experience.

3.2.6 Early Intervention, Education and Community Development

A number of stakeholders highlighted the importance of early intervention, education and community development relating to the following:

- **Children and Young People –** Importance of collaboration with Education sector to ensure that children and young people understand addiction, substance use, mental health, resilience and controlling emotions. Stakeholders feel that better understanding will reduce stigma and equip young people with the tools needed to manage their emotions without resorting to alcohol and drugs. Further, it is felt important to equip children and young people with skills and resources needed to seek help and identify harm.
- **Community Development –** Importance of building community capacity in order to de-stigmatise and to help strengthen services which are operating within communities. Stakeholders noted that some communities did not accept needle exchange services, for example, operating within their areas.
- **Primary Care/GP Awareness –** It has been suggested that clearer guidance should be available to GPs on prescribing/de-prescribing medications with an abuse potential.

3.2.7 Workforce Development

The stakeholder engagement highlighted the importance of continual professional development. Many stakeholders highlighted a great need for service provider and wider workforce training in order to allow for staff development in areas of concern. With rising complexities, increase in poly-drug use and overlap of mental health concerns and drug and alcohol use, service providers have expressed the need for a more strategic approach to training and development.

Further, several stakeholders felt it vital that all workers with a job role within the wider health and education sectors should have awareness on addiction, identifying drug and alcohol misuse and Hidden Harm, e.g. midwives receive training on smoking during pregnancy but should also receive training on substance use. Stakeholders note that training should be tiered with options of levels suitable to need. This training is not always accessible or affordable for service providers, and should be considered within future commissioning.

3.2.8 Methods of Engagement/Access

Conversations with stakeholders highlighted specific needs which must be considered when commissioning services to ensure quality for service user and best use of service provider resources. Some of the key points raised are outlined below:

- **Rurality –** A number of stakeholders outlined challenges faced by rurality and wide geographical spread – especially within some Trust areas (most notably the Western Trust). Issues with rurality include: more expensive delivery model, rural vs urban demographics within some Trust areas, infrastructure and engagement. This must be considered when looking at realistic provision and service levels with different delivery models potentially required within rural areas such as outreach focused models and floating support.
- **Out of Hours Provision –** Lack of evening and weekend provision is detrimental to service user journey and experience. Service users in crisis find themselves with no option but presenting to Emergency Services. Service providers feel that there needs to out of hours provision built into future commissioned services and noted examples of needle sharing etc. as a result of no open pharmacies in evenings.
- **Section 75 and Vulnerable Groups -** Relative to this, some stakeholders also outlined that the specific needs of Section 75 and vulnerable groups and communities must be considered at all times: homeless, pregnant women, those with other addictions i.e. gambling, BAME, young people in care, cares etc. The barriers which prevent engagement into services as well as accessibility needs within services must be considered.
- **Alternative Methods of Access –** Considering the above, stakeholders feel that services must offer alternative ways of accessing services besides face to face interventions. Services adapted to the COVID-19 pandemic by offering digital and telephone meetings/service provision which in many cases resulted in increased uptake. Whilst these

methods of communication are not suitable for every service user, stakeholders feel there should be flexibility and that services must be adapted where appropriate to meet need. Further, these methods of access alleviate challenges outlined above.

3.2.9 Family Support Services/Intervention

Whole family support has been successful, where families have bought into and availed of services, however many stakeholders have stated that uptake and family involvement has been low. Some stakeholders noted that this is an area which needs further resourced and promoted and that families should be treated holistically as units – where there is an adult using a substance in the family the wider family unit should be included in service provision; where there is a young person using a substance in the family the parents/carers and siblings should be included in provision. Where family support services were utilised by service users, outcomes were more successful.

This is relative to the importance placed on consideration of Hidden Harm by stakeholders who feel Hidden Harm must remain a top priority within services.

Several stakeholders placed great importance on therapeutic work for whole families and suggested a stepped care model for family support and Hidden Harm – a more structured family support offering which engages family in the treatment/recovery process.

In the Southern Trust, engagement of family members has been considered more successful, attributed to their Family Support Champion model – this could be a consideration for all Trust areas as part of a new commissioning process. Some stakeholders also suggested that using structured models of family engagement such as CRAFT and the 5-step model could increase uptake of services.

3.2.10 Take Home Naloxone and Needle Exchange Services

A number of stakeholders noted that there needed to be a focus on the piloting of nasal Naloxone, as well as increased training on administration of this. It was noted that Naloxone by injection creates barriers to use and that expansion of intranasal take home Naloxone may reduce these barriers. It was suggested that take home Naloxone should be available from an Emergency Department or prior to discharge from an acute hospital and should be offered to people being prescribed high doses of opioids for pain.

3.2.11 Briefer Intervention Measures

Many stakeholders expressed the need for briefer intervention/treatment services to be prioritised to allow for service users' needs to be met at an earlier stage. Stakeholders feel that the use of briefer intervention within Step 2 could help manage at-risk individuals with less severe substance use behaviours, and even suggested briefer intervention as a separate PHA commissioned service. Briefer interventions should be time limited, structured and with an end-goal or target set.

In relation to this, some stakeholders feel the pathway should incorporate client choice and encouragement of self-help options, allowing service users to get support when needed and contributing towards shorter waiting lists. Further, it was noted that there could be a service map or menu of options to allow people requiring support to navigate services and understand help available. Currently, some stakeholders feel there is an over-focus on counselling within Step 2, when focus on briefer interventions could be extremely effective. It is unclear if stakeholders were referring specifically to young people, adult services or both.

3.2.12 PPI/Service User Involvement

Service user involvement by people with lived experiences of drug and alcohol services was highlighted as a priority by all stakeholders in order to make positive and sustainable change. Service users with a history and experience of substance use and related services felt it vital their voice is included in all elements of PHA related work from the concept to design and commissioning of services. Service providers and wider stakeholders on the whole agreed that services need to be adapted and commissioned based on service user feedback and need. All agreed that this must be meaningful, non-'tokenistic' involvement which is heard and acted on by PHA. Many service users felt their input was not true co-production.

Further, some stakeholders also expressed a need for peer-led support groups and peer learning to be embedded into services for greatest impact. Whilst service users did note a positive relationship between RSUN and PHA, it was emphasised that service users must be involved as champions and mentors within commissioned services. This would bring added value to both staff delivering services and people accessing them. Comparisons were made with area of mental health where mentors/peers who had lived experience had an important role in reducing stigma, being strong advocate and championing the relevant services.

3.2.13 Research and Monitoring

Evidence based interventions are cited as key to making effective decisions around future services. Research and monitoring are both integral to this achieving this and the following are some key points relevant to this area:

Research – Some stakeholders expressed the need for more research into drug and alcohol related deaths in Northern Ireland including *'near misses'* which would help agencies develop an understanding of the issue, realise patterns and work more effectively to prevent further deaths. Further, a number of stakeholders highlighted an increase in poly-drug use and the detrimental effects of this and urge that research into poly-drug use is a vital component in understanding and forecasting future needs and services required.

Monitoring – Some stakeholders queried the Impact Measurement Tool[1] (IMT) system used by PHA and evidenced within the PHA presentation which formed the introduction to stakeholder engagement. There were concerns raised that information gathered by the IMT and presented did not represent the 'full picture'. Some stakeholders reflected that the quality of data collection across addiction services is problematic and that in order for monitoring and evaluation to be robust and accurate, the same measurement tools must be implemented by all services – PHA and non-PHA funded – to ensure consistency in data. Some stakeholders also noted that the IMT collects data in a way which is often difficult to interpret and that a regional IMT would be beneficial for use when service users move between Tier 2 and 3 services and across different Trusts. The Royal College of Psychiatrists suggested the National Drug Treatment Monitoring System (NDTMS) should be used instead.

3.3 Specific Findings

Whilst the previous section focussed on themes which were mutual in discussions on Young Peoples' Services, Community/Connections Service and Adult Services, this section looks more specifically at nuances which are specific to the respective elements.

3.3.1 Young Peoples' Services

3.3.1.1 Transition from Young Peoples' to Adults' Services

Some stakeholders highlighted the need for coherent and consistent approach to allow young people to transition from young peoples' services to adults' services. These stakeholders feel there is a lack of integrated approach with no meaningful relationship between adult and young people's providers/practitioners. This is epitomised in the difference in age limits across the different sectors with community and voluntary services applying an age limit of 25 years to mandatory transfer to adult services and Statutory service applying an age limit of 18 years to mandatory transfer to adult services.

3.3.1.2 Hidden Harm

Whilst Hidden Harm was referred to earlier in this report, it was a prominent feature of the discussion within young peoples' services. Stakeholders feel the need for a stepped care model for Hidden Harm and that targeted Life skill/ youth treatment services should have a contractual remit to respond to Hidden Harm.

Further, relative to this, it was noted that there should be stronger linkages between adult Step 2 and young peoples' Step 2 services (e.g. Targeted Life Skills Service to extend to deal with parents and not just young person).

3.3.1.3 Voice of Young People

Whilst the process of stakeholder engagement did involve service users, some stakeholders feel it vital that the voice of the young person is heard in any recommissioning or co-production process. Specifically, the nuances and challenges associated with looked after young people, those who are in a caregiving position, homeless etc are an important element to understanding substance use. Further, it is important to understand what young people want and need from a service in terms of method of engagement.

3.3.1.4 Suitability/Service Level

A number of stakeholders have outlined the need for coherent treatment plans for young people – to ensure young people have the resources they need. It was stated that there must be a suitable treatment plan for young people, who should be triaged when entering a service, to ensure the most suitable treatment which works best for them.

Stakeholders felt the need for a central point of discussion to allow understanding of the services a young person is availing of, and what other service providers (statutory and community and voluntary) are involved. Some stakeholders felt that there was often too many involved in a young person's treatment/recovery journey, which does not always ensure positive outcomes.

Further, it was reflected that there is a lack of standardisation

[1] *Measurement tool provided by Department of Health*

of services offered to children and young people for Alcohol and Drugs across Trusts. Royal College of Psychiatrists noted that Alcohol and Drug positions funded through PHA often sit within or alongside CEIS or CAMH services, but funding streams remain separate.

3.3.2 Adult Services

3.3.2.1 Vulnerable Adults

Several stakeholders stressed the need for more services focussed on 18-25 years vulnerable adults who live chaotic and often unstable lives. This group of people – including those leaving care - are currently underserviced in current provision and need separately resourced services.

3.3.3 Community/Connections Services

Whilst the Community/Connections service did form part of the stakeholder engagement agenda, it is worth noting that there was very little input in conversation around this element. This should not be viewed as a criticism of the service. Some points which were made re the Connections service are as follows:

- Need to look at how Connections service can be used as a tool for building relationships between local services and communities. Redeveloping the connection between people in communities and accessing local services they need;
- Connections could have a role in prevention services;
- Connections has been effective in forging links with local communities and partnerships with stakeholders (e.g. local Alcohol and Drug Forums in Western Area which have been effective in identifying and responding to local issues);
- Connections service should continue to have a role to support local implementation of the new Strategy in the community – to promote prevention, collaboration and access to services;
- Alcohol and Drug Responders initiative has been promising – should be scaled up to build capacity in community.

3.3.4 Trust Specific Findings

Despite individual stakeholder engagement events taking place in each Trust area there were very minimal Trust-specific nuances (outlined below).

- **Southern Trust area -** Step 2 services in the Southern Trust area, they have historically been delivered by statutory providers. Statutory services have discontinued the delivery of these, and the intention is that community and voluntary service providers will deliver on Step 2. This is seen as a positive change, with more opportunity for community and voluntary delivery agents, and bringing processes in the Southern Trust area in line with the rest of NI.

It is worth noting that there were different levels of collaboration/relationships both amongst community and voluntary service providers and between community and voluntary service providers and statutory providers. However, collaboration and relationship building was something which stakeholders prized as it is strong relationships that make services work for service users, and connections were even being made during stakeholder engagement sessions

3.4 Non PHA Commissioned Services Discussed

Although not PHA commissioned services, some relevant issues were raised consistently within engagement sessions by stakeholders, with an overview of these provided below. The PHA has stated that it will ensure these points are recorded, captured and shared with relevant agencies in an effort to explore wider strategic solutions.

3.4.1 Access to Opioid Substitute Programmes

Low Threshold services interface with Opiate Substitution Therapy (OST) Services by helping people stabilise and build readiness for the demands this type of treatment places on a service user. A rising demand for OST is widely recognised by all stakeholders, and some stakeholders expressed some concerns around how current processes in some areas inhibited the accessibility of this treatment. It was noted that opiate substitution therapy is significantly under-resourced and requires upscaling – with difficulties in access needing addressed. It is reported that efforts to encourage GPs to prescribe OST across Northern Ireland has had limited success.

It was noted that access to HSCT Opioid Substitution Therapy services (OST), as well as waiting times created a barrier in services. Some stakeholders expressed frustration at lack of rapid access to OST in some areas when people need them most and that having a consistency across NI to make direct referrals to OST without primary care intervention would be much more equitable and allow for swifter treatment. Whilst it is acknowledged that OST is not commissioned by PHA (it is commissioned and managed by the HSCB with the 5 HSC Trusts), service providers raised issues as relevant to the conversation.

Stakeholders feel that low threshold working is required throughout commissioned services to provide OST and note that Drug Outreach Teams and Low Threshold services provide this successfully. It was emphasised that a partnership approach is required with Trusts to ensure

appropriate provision and access.
The requirement for ongoing support for individuals receiving OST is highlighted as a priority – ensuring recipients receive ongoing support and encouragement on their journey, and help with navigating further support services if required.

3.4.2 Rehabilitation and Secure Accommodation

Although it was also acknowledged that provision of accommodation is a Housing Executive responsibility, and that inpatient treatment and rehabilitation services are funded by the HSCB, some stakeholders highlighted the need for, and importance of, low threshold safe and secure accommodation options for those using alcohol or deemed 'at risk'. It was noted that hostel accommodation often further aggravates substance use and that loneliness and isolation are often triggers for substance use. A number of stakeholders felt that secure accommodation with experienced staff and therapeutic activities would alleviate further risk and therefore reduce pressures on higher threshold services. With specific reference to the homeless sector, many stakeholders felt that homeless people needed outreach support and safe accommodation away from hostels which often lead to accelerated substance use/which do not lend well towards changes in decreasing substance use – abstinence and recovery. Several stakeholders referred to the Housing First model as a model which could be adopted in Northern Ireland.

Further to this, stakeholders outlined a need for more inpatient rehabilitation services in Northern Ireland with the concerns expressed that rehabilitation facilities are available only as a 'postcode lottery' and to those who can afford them.

3.5 Outcome of HSCB Stakeholder Engagement

As outlined previously, a stakeholder engagement session with the regional HSCB / HSCT Tier 3 & 4 Addictions Group ran simultaneously to this stakeholder engagement exercise. The discussions from the HSCB / HSCT Tier 3 & 4 Addictions Group engagement presented themes as follows:

- **Outcome Measures** from the measurement tool used by PHA[2] with services were hard to read, too vague and potentially misleading. It would be important to agree a whole system approach to outcome measures. This concurs with similar criticism from other stakeholders as outlined previously.
- **The Tiered System** is unsuitable for an effective coordinated care pathway and causes significant overlap and duplication of effort. It was expressed that many of the services providing interventions were limited to 1-1 counselling/support and were understaffed. It was thought that aligning Community and Voluntary services with a recovery pathway would be valuable, enhancing their roles in supporting recovery would significantly strengthen the gains made in initial changes guided by treatment.
- **Build Community and Voluntary sector expertise** in helping people into treatment and supporting recovery post treatment. A plea was made to develop low intensity community-based group programmes that patients could access at the early stages of recovery when they are trying to establish healthier peer relationships. Supportive drop in's such as recovery cafes was also requested.
- **Break Down Interfaces between Tier 2 and Tier 3** services should have joint meetings, collaboratively planning care with the service users at the centre and removing the administrative 'hand offs' that often build in waiting times and result in losing people.
- **Delay Procurement -** a strong and clear consensual voice was expressed to work in tandem with the Substance Use Strategy – 'Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use'. Participants were hopeful that the PHA could find a way to delay this process to benefit the opportunity that will help achieve more coherence with the new strategy.

Recovery pathways featured most strongly during this brief engagement session and some innovative ideas were suggested such as developing access to self-directed payments and social prescribing activities.

[2] *Measurement tool suggested by Department of Health*

4.0 Conclusion

The stakeholder engagement process has allowed for meaningful feedback from those affected directly and indirectly by PHA commissioned Drug and Alcohol services. It is extremely important that in light of this, the PHA considers the findings from this exercise, plus other key stages yet to happen, and implements change in future commissioning and service provider contracts where necessary. Any change needs to be based on a robust evidence base and deliver better outcomes for service users.

Unsurprisingly, some discussions and feedback went beyond the scope of PHA commissioned services. This reflects the inextricable links between many of the drug and alcohol services, whether they are PHA or other HSC funded services. It also reflects many stakeholders primary focus on looking at the holistic journey and experience of people affected by substance use and the interdependence which exists between various services.

Stakeholders applauded PHA for its communication and flexibility as a commissioner/funder. It is important, as expressed by stakeholders, that the PHA continues to be open to flexibility and fluidity within commissioned contracts to ensure services can adapt to what they describe as 'ever changing' and 'evolving' needs. Stakeholders acknowledged that whilst it is important to remain accountable to the investment received, it is vital they are not tied down to restrictive objectives and that they can be responsive to unforeseen circumstances – as was the case in 2020 with the COVID-19 pandemic. Further, they reinforced the need to prioritise service user needs and the importance of engaging service users for a longer period of time, if required.

Whilst stakeholders welcomed the opportunity to contribute to this process, and the PHA should be recognised for its willingness to include stakeholders in future decision making, it is important to note the issues highlighted around the timing of this process. Many key stakeholders believe that consideration should not have been given to the PHA's planned re-procurement of Alcohol and Drugs services before consultation for the New Substance Use Strategy – 'Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use'. It must be recognised by the PHA that stakeholders are concerned that decisions made based on outcomes from this stakeholder engagement exercise may be premature, lacking synergy with outcomes outlined in the new Strategy. In turn, this may lead to a commissioning of services which are not fit for purpose or based on the Strategy's priorities. The complex and multi-faceted issues within the area of drugs and alcohol, clearly require a cohesive and systematic approach to commissioning from across HSC.

Within this engagement exercise, perhaps the strongest priority reflected by stakeholders is for greater alignment of Alcohol and Drugs and Mental Health resources, to take into consideration the complexities of dual diagnosis/co-existing mental health and substance use and the services which affected individuals require. This is a massively complex issue and some of this is beyond the remit of PHA, but this should not deflect from influencing changes within the wider system.

There may be opportunities for the PHA to look inwards to look at what is feasible in pooling Alcohol and Drugs and Mental Health resources for a more all-encompassing approach to commissioning to ensure a better outcome for service users. This may, in fact, lead to a more streamlined way of working and therefore a more streamlined service for service users. Workforce development and further upskilling of those involved in drug and alcohol services to deliver low level mental health interventions may be an approach to be considered.

The need for Alcohol and Drugs teams and Mental Health teams to co-ordinate and work simultaneously relates to the general need for pooling resources and working collaboratively within the sector which, although it happens on an ad hoc basis amongst community and voluntary stakeholders and between community and voluntary stakeholders and statutory stakeholders, lacks a systematic 'top-down' approach. Stakeholders have urged the PHA to work alongside other statutory bodies and Government Departments to ensure a wider view of health and other social aspects. Further, stakeholders also reflected on their own practice and recognised the need for more consistent and proactive communication between service providers.

Stakeholders recognise that demand for services is extremely high, with waiting times and referral pathways remaining a challenge. There are key services which are not commissioned by PHA (e.g. Opioid Substitution Therapy services) but which have featured prominently in this stakeholder engagement, and are considered to be of critical importance for effective treatment and recovery services. The PHA again has a role as a commissioner to work with other HSC commissioners to ensure gaps like this are addressed.

This process has suggested a sub sector which is maturing and developing through a consistency in funding over a reasonable period of time. Relationships appear to be reasonably strong between the key organisations involved in service delivery, and for the most part with statutory organisations within each Trust. This could not be assumed to be the case across the board and there do appear to be some disparities.

Where these relationships are strongest, it appears to have positive implications for outcomes experienced by service users. There is clearly still more to do in this area to maximise the efficiency and effectiveness of services across the region. Separate commissioning of drug and alcohol services and cultural/operational differences between community and voluntary sector and statutory sector by their sheer diversity will naturally continue to be a challenge in achieving a truly joined up and seamless service. This exploration with stakeholders has indicated that improvements have been made and are possible, and there is a genuine commitment to continuing to develop better ways of working together to improve pathways for people working in and using these services.

This exercise has shown that service providers involved have staff teams who are skilled, empathetic and who care about achieving positive outcomes for clients/service users. Service providers show concern for clients well beyond the scope of their role in what is extremely challenging and demanding work. It is important that the staff employed within Alcohol and Drugs services are fully trained and can avail of professional development opportunities which allow them to continue in their roles safely and confidently. This in turn will add significant value to the services provided to children, young people, adults and families/carers impacted by drug and alcohol use. Service providers urge further resourcing to the family intervention services to ensure whole family support is available and specific interventions for Hidden Harm.

This report and the engagement undertaken which informs it will not be taken in isolation. Robust evidence on the impact of current services is also key in shaping future services. It is however a key step in a series of stages to be taken forward by the PHA in shaping future Alcohol and Drug services for Northern Ireland. The time, commitment and contribution of all stakeholders to this stakeholder engagement process is laudable and very much appreciated by all involved.

Appendix 1

Notes from Stakeholder Engagement Events & Online Survey

Service Users

Gaps and Barriers:

- Needle Exchange services in Belfast – pharmacies close at 5:30/6:00pm which means there is no provision in the evening. This means people share needles. More night time services needed.
- Links needed between Drug Outreach Team and EXTERN. Link-ups are non-existent.
- Support ends when people are no longer substance reliant/dependent. Nowhere at this point to go for support to prevent relapse.
- Can secondary/outside parties inform on issues. Outside influences on drugs and alcohol – look at influence of Benefits etc.
- Some service users had noted no follow up.
- Too much focus on 'keeping spending down'.
- Lots of services fighting for funds – creates competition and organisations then distance themselves.
- Lack of service user involvement:
  'Service user involvement is key'
  Service user involvement should be a requirement of services and should be part of PPI.
  Service users 'should be seen as valuable human beings... so essential to make these services work'.
- Stigma – "When people realise it is a health issue and not a criminal issue these things can be taken forward".
- Organisations are too driven by deadlines.
- Mental health staff not trained in drugs and alcohol – should be done through Recovery Colleges as training is co-produced.
- Key services like the holistic approach used by FISA (now ended) not available to help with withdrawal.

Solutions to Gaps/Barriers:

- Need ongoing support. 'People are getting lost in a system and then relapsing'.
- Peer support networks for people leaving a service – one on one support to build a relationship.
- Need to address connection between mental health and drugs and alcohol – these two areas do not 'talk'.
- How do we ensure consistency and accountability when we don't have an independent and verifiable method of feedback in order to improve services?
- Regular lapse/relapse sometimes is only picked up at secondary group level or by someone who is in the community – sometimes the reason of this is not fully explored. Maybe looking at close intervention or regular lapse/relapse via peer support in this instance could be an avenue to explore.
- Service user involvement is key – 'It would improve confidence to represent all voices. Seems shocking that service users are not involved in every aspect of developing services. Makes it look like service users are deemed 'not reliable' or 'not together enough' to contribute'.
- Service user engagement seems 'tokenistic' and often a 'light touch'.
- Service user engagement often is not deep enough, no true connection to people with lived experience.
- "We are part of the community so why are we not part of the service development?".
- Relationships between service users and professionals are key – often challenges around stigma etc.
- Organisations and groups need to make change for disability access and equal opportunities.
- Co-production.

What has worked well:

- Good relationship between RSUN and PHA – network has really developed but need continuing support

Adults' Services

BHSCT Adults' Services

What has worked well?

- PHA much more responsive to commissioned services – flexible approach.

Gaps:

- Weekend provision would be a huge improvement. People presenting to ED in crisis at weekends but not limitations to weekend services.
- Services are not growing as fast as drug and alcohol use has – increase in heroin injecting, cocaine use etc. Problems in Belfast are outweighing services available there. Capacity needs urgently addressed.
- Substitute prescribing not fit for purpose for those who need it – needs to be upscaled and resources and difficulties in access need to be addressed.
- Access to methadone programmes is 'horrendous'. When patients get a prescription it is not a sufficient dose. These individuals are often not being listened to and treatment is not sufficient. Methadone programmes are not fit for purpose. Need an empathetic approach to their lifestyle and to look at what can be done to keep people in a programme.
- Many services available in Belfast are not advertised appropriately and practitioners do not know the range of services available.
- Need more awareness and education at community level – communities are fearful of drugs and label drug users engaged in drug activities. Lack of awareness about what drug addiction is. Opportunity to step up community

awareness and education. This impacts on those who are trying to find help.
- Need for multi-disciplinary teams to deal with Mental Health and Drug and Alcohol issues together – currently dealt with separately which is a 'flaw'. The two elements cannot be disconnected. Need better points of access/ treatment plan for people who require help for both mental health and drugs and alcohol.
- Rehab opportunities can be availed of if people can afford them. Otherwise there are no rehab facilities in Northern Ireland for those who cannot afford them.
- Some services existing could be better configured to deliver a better service for those who need it.
- Need joined up working at a statutory level – silo mentality.
- Speed of access to services.
- Difficulty of access – referral process has to work – need for self-referral. Self-referral = clients with control over their care when they are at their most vulnerable. Help at the right time is essential.
- People are falling between the cracks in general – difficulties in accessing two services rather than one (mental health/addictions) – two different entry criteria. A single point of access and referral between services is needed.
- Considerations for B&ME community.
- Continuity of services is very important – contract length ensures services can be planned, staff can be retained, and knowledge can be kept within an organisation.
- Need a pot of funds which can allow services to quickly respond to evolving needs – needs are arising quicker than commissioning contracts.
- Sometimes how contracts are written it doesn't allow services to be flexible – if contracts are longer-term there needs to be flexibility built in.
- Need for improved pathways in and out of services – streamlined for service user.
- Need for residential support/treatment facility which is statutory – PHA depends on community and voluntary organisations for residential treatment. Needs to be a facility in Belfast. This would allow people to stabilise and move back into community.
- Difficulty accessing low threshold support – lack of services for those not using alcohol or opiates – services available in other areas but not Belfast – feels like a postcode lottery.
- Referral pathways via GPs can be difficult.
- Service provision for people frequently in prison needs to be addressed – often come out of prison for short periods and on remand with worse drug use issues – often end up in ED within 48 hours of release.
- Mapping process through community and voluntary services and statutory services - assertive outreach across the board. Increase understanding of available services and improve collaboration.
- PHA could fund support workers to key work, OST clients to take pressure off Trust OST services so they can focus on induction of new clients.
- Rapid low methadone prescribing for those opioid dependent people who are homeless – provided outside the Trust by a voluntary agency.

WHSCT Adults' Services

What has worked well?

- Floating support and flexibility – good feedback from service users – large geographical area to be covered.
- Very good connections within organisations.
- Very positive relationships with PHA -flexibility etc. Future funding should keep this fluidity and flexibility in mind. I.e. response to Covid – allow services to be adaptable etc.
- Very good understanding of service user need – allows quick response and to pivot quickly with funder (PHA).
- Step up/down approach advocated for.

Gaps:

- Huge amount of complex mental health issues coming to the fore. Needs to be a big focus on mental health going forward. Need also for dual diagnosis training – limited opportunities for staff training. Too expensive for services to fund – need support around this.
- Staff need dual diagnosis and mental health knowledge. Complexities rising along alcohol and drug misuse.
- Services are under pressure with high demand – waiting list – services trying to keep waiting lists at reasonable level.
- Family side of services has not been used well. Family members seem to not want to engage in services.
- Need provision for longer term support within services.
- Social issues – homelessness, mental health issues, family complexities.
- Need help with working with people and managing behaviour.
- Pressures of rurality and geographical spread – floating support is increasingly important.
- Tighter process of moving out of low threshold services. Can be very difficult for service users. Defining the point – exit strategy at end of process that service user can be reengaged. More refined and consistent approach in low threshold services.
- Increase in alcohol and drug use, poly-drug use – issues with bigger uptake of illicit drugs.

- Increase in need for Naloxone training in communities and within families.
- Stepping up from step 2 to step 3 services – can be difficult for some to navigate pathway. Some cannot refer into Tier 3 – most of these come from primary healthcare. Although 2 and 3 services are working together it can be difficult referring in.
- GP/MDT concern that referring to services is overwhelming services – can then be detrimental to client. Primary to secondary referrals – considerations for volume etc.
- Wraparound approach is hugely important in future contracts – ensuring a client is getting everything they need.
- Need services to be flexible based on need – if someone needs longer term support there should be a breadth of support to ensure they do not fall off plan. This means being realistic as on other side of the coin services become overwhelmed – people do not leave case load – returning to services creates even more overdemand.
- Creating avenues towards independence for service user's cohorts – social factors, financial freedom etc. Will take away from dependency on services. Service users and complexities means that work develops very slowly, and services can become a crutch.
- Whole person approach is key – accommodation is key, good quality services to deal with drug and alcohol issues. Education, training and employment key.
- Western Trust services feel like a postcode lottery – people should have access no matter where they live in the area.
- More access to third level training in relation to dual diagnosis training is needed.
- Need for better relationships amongst services and Community/voluntary sectors.
- Need for more workforce development training – NIADA launching survey with QUB which acknowledges need for more training in workplaces – substance use in workplace is more considerable than first acknowledged.
- Concerns around timing of approach – commissioning services not a good idea in advance of strategy being consulted on and implemented.
- Support for older age group – adults over the age of 50. Evidence base available to show that age-specific services work and are beneficial.
- If contracts move from one vendor to another there needs to be a handover period built in – empower new service provider.
- Needs to be more co-working/joined up working/ collaborative relationships between health and homelessness.

SEHSCT Adults' Services

What has worked well?

- Online/Zoom sessions which are becoming more prevalent during COVID-19 have increased attendance rates. Cancellations have decreased – people often could not afford transport etc. Good option for people who are socially anxious etc.

Gaps:

- Under-demand for family element of services – focus on service users and perhaps not enough engagement with family members. Important to consider the needs of children in families where substance misuse is happening. Hidden Harm and safeguarding – the bigger picture.
- 5 step model needs extended for counselling for family member. Wider family members need supported. 5 steps for family members. Lockdown has forced exposure on family members and how families are not coping when 'locked down'. Need for 'tap-in' services, systematic work, couples work.
- Waiting lists are currently so long that it is hard to find time to work on family promotion.
- Online services must be a part of the work of commissioned services going forward.
- Information sharing between services must be strengthened. Look at the best interests of service users.
- Look at relationships between mental health and drug and alcohol services – relationship between these. Design how they work together from the start.
- Grey area in interface between step 2 and 3.
- Risk that if a service provider does not win a tender the relationship building process with peers, clients, service users etc has to restart.
- Step 2 services are not using the same screening tools as community addiction team. Different screening tools used by statutory and voluntary sectors. This is an obstacle in following referral pathways.
- Need direction around workforce development, where skills need built, gaps etc. Workforce development programmes are not really built on strategy. Workforce/ early intervention services are needed.
- Audit tool is not a particularly good tool. More work regionally needed in getting outcome measurements.
- Tier 3 services often taking on tier 2 services to try and reduce waiting lists.
- Seeing an increase in self-referrals – due to GP/MH services being under pressures associated with COVID 19 and waiting lists too long.
- Need access to emergency funding to react to pressures.
- Commissioning is still happening in silos.
- Looking at inequalities is very important – not all service

users will have access to digital services etc. This must be considered in the process.
- Process mapping should be used in all services.

SHSCT Adults' Services

What has worked well?

- Southern Trust have been able to engage family members. Family support champion – embraced and embedded.
- Mentoring and coaching has existed in Southern Trust – important to support people delivering.
- Positive working relationships. Referral pathway could make relationships stronger – works when can refer directly into a service.
- Flexibility and support from PHA has been positive.
- Easy access and self-referral approach worked well. However this is not there in Step 3 – GP or health profession.
- Outreach services going directly to service user's houses has been restricted due to COVID-19.
- Digital meetings/remote working has been working well, though is dependent on needs of individual. Attendance rates have been higher year on year. Helpful to allow people the choice.
- Positive that there will be new opportunities opening up within Tier/Step 2 with involvement of community/ voluntary sector following services being delivered by Trust.
- Exciting time to build partnerships (Trust with community and voluntary) – will be good to have this progress made in Southern area.

Gaps:

- Works when can directly refer in to services – can't with alcohol services. If could refer directly in it would help in long run.
- Frustrations with having to go through GPs/health professionals for referrals.
- Dual diagnosis – Huge issue for people in terms of accessing services. Something which needs addressed. Training is not easily available for staff – not a huge amount of resources to support individuals. Service providers have to fight to get service users the support required. Training needs to be more readily available. Rise in mental health issues and with addiction issues alongside these. One service might block access to another when services need to work hand in hand.
- Dual diagnosis service exists within Tier 3 – limited ability to refer into this service. Issue within Tier 2 services – deficit within Tier 2 in terms of referral pathways in to dual diagnosis etc. Frustrating/difficult situation as mental health and drug/alcohol misuse needs are increasing.
- Service user groups do not always have ability to wait, follow processes etc. Need to develop pathways which are flexible, and which will meet the needs of individuals. Need to share information so they are getting the right support – joined up approach and thinking around overall package of support.
- GDPR can prevent helpful data sharing. Service user data sharing agreements needed.
- There is still a stigma for individuals accessing GP/CAT support – they may not want to go. Benefit of community and voluntary services is they are flexible, can work on harm reduction, anxiety, low moods etc. Medical model does not suit all. Inclusion of skills training, ARCH programmes, creative outlets, hiking, connecting individuals for ongoing support after treatment has ended.

Unique point that Tier 2 was delivered by Southern Trust but has now ceased.

NHSCT Adults' Services

What has worked well?

- including service users – especially at peer mentoring level – this can be extremely beneficial.
- Connections between service providers are strong in the Northern Trust.

Gaps:

- Consider the impact of poly-drug use – causing most harm. People are presenting with a range of complex problems.
- Tier 2 and 3 operate with different referral pathways – need a consistent approach.
- Important to maintain people in their own accommodation. Temporary accommodation facilities can have a negative impact on journey. Housing First model is a good model.
- Commissioned services need to have a 5-7 year contract length – any less can create problems in service consistency, staff loss, skills loss.
- Need for flexibility and ability to respond to changing needs.
- Consider model like the Doncaster Model.
- Need for a wraparound holistic service for clients – housing, benefits, services – look at all the factors which come into play or impact a person's journey.
- Considerations needed for care-leaving adults.
- Considerations needed for care-givers.
- Training needs must be met – vital to have a trained workforce who can identify need. Whole healthcare workforce must be trained to recognize drug and alcohol misuse – i.e. training midwives to scan for alcohol abuse and make referrals from this. There are funded roles for midwives in relation to smoking and pregnancy but not

drugs and alcohol. Important to have a footprint across all health services.
- Mental health and drug and alcohol addiction often have a relationship – these two sectors should not operate separately – need for a joined up approach. Feel there has been no improvement in joined up working in relation to MH and D&A.
- Outcome measures must capture where people are at the start of their journey.

Community/Young Peoples' Services

BHSCT Community/Young Peoples' Services

What has worked well?

- Flexibility for young people – meeting young people where they are. This flexibility needs to be maintained.
- Family element works well – including family and systematic element of Daisy service has provided support to whole families.
- Length of contracts – must ensure contract lengths are 5-7 years. Otherwise this can destabilise and be detrimental on client.

Gaps:

- Not always just drug and alcohol issues – different/ several underlying issues often co-occurring. Need for collaborative working and sharing of information.
- Service providers need to come together to highlight gaps/share concerns in young people's treatment – young people often accessing services from more than one service provider.
- Extra training needed for staff.
- Need to include the voice of young people in commissioning processes.
- Crucial to understand the prevalence of poly drug use.
- Need to look at opioid overdose within young people – how to resource families with Naloxone to avoid opioid overdose.
- Lack of co-terminosity of public service/PHA sectors. Does not allow coherence/consistency for young people. Transition issue from young people to adult services – services are not designed to meet their needs. Lack of integrated approach.
- Strategy should be agreed/implemented before this process. Wait for new strategy and then build on the learning. Co-designing/co-producing in tandem to meet client needs.
- Need for more family integration and support especially for young people who are still living at home.
- Considerations for homeless sector and looked after children.
- Young people's lives are chaotic – readiness is very important. Need to operate with flexibility.
- Coherence in young people's treatment plans – ensure young people have the resources they need. Currently no framework for this. Need to take a step back and look at/ triage the young person – who do they work with, what works best for them. Often too many referrals at once for young person. Often too many involved in young person's treatment/recovery journey – does not always ensure positive outcomes. Need for a central point to discuss young person and the services they are availing of.

- 18 years + vulnerable adults – needs consideration – key issue.
- Workforce development is extremely important.

WHSCT Community/Young Peoples' Services

What has worked well?

- PHA consistency in commissioning of services across NI
- Have always been able to communicate need to PHA contacts and this has always been responded to. This is welcomed.

Gaps:

- Parents struggling with young people – family intervention numbers are higher than ever before. More focus on this area – better resourced.
- Mental health, homelessness, care system – so many complexities with young people.
- Rurality in Western area – Derry City has good engagement but more rural areas it seems to be harder to get young people involved. Not coming forward independently – only when referred by social services etc. When young people are sent to a service, they are not always willing to cooperate. Distance to travel can be timely – especially southern sector of the west.
- Difficult for young people to get mental health support.
- Mental health and drug and alcohol co-exist – need joined up working to resolve these issues.
- Must look at family situation and assess the whole unit.
- Need to look at schools and communities – people will not know they have a problem if they do not have the knowledge of what a problem looks like.
- Joined up working with all services working with a young person.
- Hidden Harm – need focused support for these particular groups.
- 18+ cohort (especially those who have been through care) – there has been so much instability in their lives that this group need separate focused services.
- Upskilled workforce are required to deal with young

people's issues – huge host of traumas, experiences and issues and it is important to stay aware and trained to deal with these.
- Providing healthy alternatives to alcohol/drugs and alcohol. Encouraging healthier choices and supporting this.
- Flexibility within services to deal with other issues facing young people – sexual health, mental health. More seamless approach than having to refer individual into another service.

SEHSCT Community/Young Peoples' Services

What has worked well?

- High quality staff members – Well trained, high quality staff are a solid foundation for a service. People are then there to support young people and are the connection and relationship which make sure everything works well. Consistency of staff is important.

Gaps:

- Transition between young people and adult services. Many young people have chaotic lives and must make sure there is a relationship between adult and young peoples' services.
- Within young peoples' services there is not always clear transition pathways. Needs to be thought around maximising opportunities to connect young people into right services whenever they need them.
- Targeted prevention service needs to engage with parents/carers and families. Important to engage families and current models have no scope to work with parents.
- High density of complex presentations across all services. Current barriers to treatment and structure of funding make it difficult to stay engaged with service users. Multi-disciplinary working important and shared care recovery planning.
- Joined up working is required from statutory level. Currently joined up working is from the 'bottom up'. There is a will to work together within services but needs a strategic lead.
- A more succinct and seamless process/service required for young people. Flexibility to be able to access family therapy, therapeutic work for families at any stage of journey through service. All are very separate currently.
- Mental Health and Drug and Alcohol – two issues co-exist but services are separate. These services need to have a more joined up approach.
- Hidden Harm – specialist Hidden Harm service but no stepped care model of support for those living with parental substance abuse/Hidden Harm issues. Hidden Harm identified as priority area – need stepped care model for addressing Hidden Harm. Until 2015 youth provision services had a remit to take referrals for young people with Hidden Harm but this no longer exists. Missed opportunity.
- Connections – exists within this discussion but not a young peoples' service. Need to look at how connections service can be a good tool for building relationships between local services and communities. Connection sometimes lost between people in communities and accessing local services they need. Connections should also have role with in prevention services.
- Need for flexibility within contracts.
- Special Educational Needs need to be taken into consideration – SEN children with problematic drug and alcohol use. Becoming more prevalent. Needs to be considered in new tendering structure.
- Need to look at young people and holistically. This was taken out of targeted prevention.
- Need to consider the roles of all service providers – some young people are over-serviced. Need to understand what services young people are availing of and what is working for them. Necessary to engage with other people who are involved in young person's life – working together needs to be encouraged for an actual collaborative approach. Shared care approach in looking after young people – particularly where there is higher risk. Often a reluctance to hand over or work collaboratively. If a range of professionals are involved in a young person's life there needs to be a collaborative, consistent and organised approach.
- This approach may need a statutory lead.
- Young peoples' services need to put more effort into chasing after young person, getting them engaged and not giving up on them.
- Services must have flexibility – last commissioning assigned/stuck services to specific boxes. Need to be able to be responsive – based on people and not units.
- Commissioning must make a commitment to young people. Services must be able to truly commit to change. Young people will not commit unless a service is committing to them.
- Considerations need to be made for young people in care.
- Issue of timing – commissioning services before Drug and Alcohol Misuse Strategy published. Commissioned services are restrictive and will lock services into a particular way of working which will be harder to adapt. Wait on publication of strategy.

SHSCT Community/Young Peoples' Services

What has worked well?

- Very good working relationships within Southern Trust and with PHA.
- Working with young people in ways which work for them.
- Allocating specific staff member to family support – working with families and developing relationships.
- Online telephone and digital support – training staff up to work with this.
- Better outcomes for children if parents/carers are involved in the process.
- Step up/down options within services has been good.
- 'Adopt a family' approach. Whole family approach needs to continue – outcomes for children much better if adults/parents engaged in the process.
- Professional network meetings useful in developing relationships over length of contracts.
- Hidden Harm must remain a part of the agenda.
- Positive relationships with Family Support Hubs. Family Support Hubs are good at linking young people and families into other services available into their area.
- Positive ways of working with young people – mindfulness, artwork (Articulate-create), story writing sessions.

Gaps:

- Must look at wider family unit.
- Workforce development and training – family approaches to address Hidden Harm/parental substance misuse. Any service focussing on these must be thinking about how children are being affected, kept safe, who is supporting children if adults are in cusp of addiction/alcohol addiction or misuse.
- When children are supported by services they return to family or care system – this whole system needs to be involved in support to ensure all are on board with treatment/journey.
- GP referral habits need to be looked at. They are an important referrer – reduction since COVID-19.
- Positive relationships with Family Support Hubs however sometimes the needs cannot be met by service providers.
- Drugs and alcohol awareness raising has to be part of every youth worker's engagement with young people. Young people are out on the streets more – especially since COVID-19 restrictions.
- More online services could be introduced especially during evenings and weekends – access to an online forum.
- More artistic, creative means of involving young people and more flexibility to do this. Including meditation, mindfulness. Ability to give young people skills to self-regulate their emotions – may mean that they then may not reach for substances to regulate emotions.
- Need to link mental health and drugs and alcohol at a commissioning level so that the programmes are interlinked.

NHSCT Community/Young Peoples' Services

What has worked well?

- PHA approach has been helpful and supportive – flexibility.
- Staff connections with young person are key – relationship and build-up of trust to ensure more trauma is not created etc.

Gaps:

- Need to consider the situation caused by COVID-19 – spike in young people using alcohol.
- Services are at capacity and there are waiting lists – while PHA are helpful with this it can cause pressure on service provider and impact client journey.
- Needs of young people through service doors are very complex.
- Dual-diagnosis issues – mental health and drug and alcohol issues which co-exist, young people are very chaotic and high risk. Young people need a holistic approach – joined up approach to treatment as it is unknown whether drug and alcohol misuse causes mental health issues or vice versa. Threshold for CAMHS and mental health services is very high – drug and alcohol service providers are then left with the risk and staff can feel out of depth.
- Would like to see joined up approach from the top working through the stepped process. Work through referral pathways with statutory organisations to meet needs.
- Need a seamless approach to stepping young people up and down – organised from the top.
- Need for more flexibility when working with young people – i.e. allow for longer duration of service (without creating dependency on service).
- Relapse needs to be recognised as part of the recovery journey – young person should not have to start at square one after relapse.
- Smoother pathways required for service users moving across Trusts. Moving Trust to Trust often sets young person back in their journey – client needs to be able to take their referral level with them.
- Commissioned services need to be able to remain adaptable and to change components depending on service pressures.
- Hope that new investment will divert some pressures.
- Need to acknowledge how to deal with young people in school setting – importance of education and early intervention. Also how to educate and reach those who are NEET, homeless – some slip through the gap.
- Coleraine, Ballymoney, Ballycastle need more robust services and a better offering i.e. drop in centre.
- Role of MDTs and linking in with other interventions.
- Need for more rapid access to drug and alcohol services for young people when they need help. Seems to be a gap for young people in crisis – quick access to residential

centres, drop-in.
- True need for partnership working and clear pathways – service providers need to know what each other are doing/how progress is being made with young person.
- Sometimes young people are over-serviced – all service providers should have a specific role.

Regional Service User Network Engagement

Gaps and Barriers:

- Needle Exchange services in Belfast – pharmacies close at 5:30/6:00pm which means there is no provision in the evening. This means people share needles. More night time services needed.
- Links needed between Drug Outreach Team and EXTERN. Link-ups are non-existent.
- Support ends when people are no longer substance reliant/dependent. Nowhere at this point to go for support to prevent relapse.
- Can secondary/outside parties inform on issues. Outside influences on drugs and alcohol – look at influence of Benefits etc.
- Too much focus on 'keeping spending down'.
- Lots of services fighting for funds – creates competition and organisations then distance themselves.
- Lack of service user involvement:
  'Service user involvement is key'
  Service user involvement should be a requirement of services and should be part of PPI.
  Service users 'should be seen as valuable human beings... so essential to make these services work'.
- Stigma – "When people realise it is a health issue and not a criminal issue these things can be taken forward".
- Organisations are too driven by deadlines.
- Mental health staff not trained in drugs and alcohol – should be done through Recovery Colleges as training is co-produced.
- Key services like the holistic approach used by FISA (now ended) not available to help with withdrawal.

How can gaps be addressed:

- Need ongoing support. 'People are getting lost in a system and then relapsing'.
- Peer support networks for people leaving a service – one on one support to build a relationship.
- Need to address connection between mental health and drugs and alcohol – these two areas do not 'talk'.
- Service user involvement is key – 'It would improve confidence to represent all voices. Seems shocking that service users are not involved in every aspect of developing services. Makes it look like service users are deemed 'not reliable' or 'not together enough' to contribute'.
- Service user engagement seems 'tokenistic' and often a 'light touch'.
- Service user engagement often is not deep enough, no true connection to people with lived experience.
- "We are part of the community so why are we not part of the service development?".
- Relationships between service users and professionals are key – often challenges around stigma etc.
- Organisations and groups need to make change for disability access and equal opportunities.
- Co-production.

Written Survey Responses

Part A: Young People & Community Services

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

- Hidden Harm needs vitalised. No stepped cared approach to services. Early intervention is missing.
- With the notable exceptions of the Recovery College and 12-step groups we believe that there is a need for more peer-led support groups and, from service providers, broader encouragement for service users to attend them and benefit from them. We recognise that 12-step and faith-based groups have played an important part in supporting many people, over many years. However, other forms of recovery, peer-support and service user involvement groups would be welcomed. We are not aware of any work to investigate the causes/drivers of ever increasing polydrug use among young people in NI and a strategy to tackle it and the associated risks. Extern welcomes discussions to expand naloxone provision to young people aged 14+ in NI including: (1) Young people who use opioids themselves and at risk of overdose, (2) Staff working with the above YP, typically in residential care facilities, and (3) YP who live with someone at risk of opioid overdose e.g. a parent.
- While many of the current services are exceeding their targets, in some cases there is a perceived lack of visibility of services in local communities. Feedback has indicated that some regionally commissioned services are not always perceived as having a presence on the ground therefore promotion of services and accessibility a can be an issue. Local organisations have also highlighted the need for services specifically targeted at woman and older people as there is a growing need among these groups. The impact of parental substance use on the emotional wellbeing of children continues to be an issue and further continued investment in this area would be welcomed. The need for accessible and online services should be prioritised, particularly in rural areas where the transport network is often poor.
- There is no real prevention work or resources for young people outside of targeted education, which does not meet current needs. There needs to be a coordinated approach to engagement which is holistic to include

mentoring, befriending and recovery. Services need to be more willing to engage and work in partnership with each other and non-drug and alcohol related services. Specialised training should be provided to equip staff to a degree or greater standard. There should be worker based working groups to discuss individual cases alongside family support hubs. More joint up approach around mental health support services with drug and alcohol services.

- There isn't a stepped care model for Hidden Harm. There is no remit within the Targeted Lifeskill or Youth Treatment services to respond to Hidden Harm. These services should be able to work on prevention and intervention approaches to Hidden Harm and have a pathway into the specialist Hidden Harm services. There should be a clear pathway for Hidden Harm between adult step 2 and young people step 2 services also. Targeted Lifeskills Service does not deal with family, it should engage parents as well as young people. The service could also extend to deal with other related risk issues such as mental health, sexual health, relationships etc.
- There are 2 service providers delivering services in the Mid Ulster district area. One for the Southern Health area and the Northern Health area. Programmes can vary across the 2 providers causing inequitable provision in the district.
- Waiting lists and transport to and from appointments
- Mid Ulster Council area being split into two separate health areas with different service providers for the same service. The services should be provided by one organisation across the whole district.
- Dual diagnosis ,Self-medicating, rural services and falling between services.
- Lack of visibility too restrictive.
- Not enough services to meet demand and not enough joined up working to ensure high risk young people also not fall through the gaps.

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

- Equity across the region.
- From the information available to us low threshold services appear to have been successful in terms of engaging service users. The Connections service has been well received and we would welcome the opportunity to facilitate the further involvement of this service within local communities in conjunction with community development in the Trust.
- The movement towards working with younger adults has proved beneficial.
- Regional consistency. Lifeskills service has a strong reach High levels of delivery. Youth treatment services have high levels of engagement and include family supports Well known services with established relationships with referrers Outcomes focus shows impact.
- Counsellors calling out to see young people in their homes/accommodation.
- Local providers not regional models.
- One to one support with locally based services. Services which have taken years to build up their knowledge of how to approach young people appropriately. Services which do not sit in the office waiting for referrals, those who go out to where the young people are and interact with them; build a relationship and trust with them.

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

- There is a mismatch at times between what community services and treatment services provide. There are significant numbers of people attending our community support services who are struggling with their use of cannabis, cocaine and polydrug use who do not meet the threshold for addiction treatment provided by the Trusts or are not deemed a priority for treatment. A potential solution to this could be integration of the addiction treatment service within the physical locality of the community service provided. This allows for cross-fertilisation of ideas and approaches. The meaning of the term 'community' to those working within Trusts, should be broadened from the narrow perspective that it is merely another healthcare facility, just not a hospital.
- Targeted prevention remains difficult to evaluate and further scoping of evidence based models / programmes would be welcomed. Building capacity of teachers to provide awareness, intervene and signpost to existing support services should be done in collaboration with EA to ensure best possible outcomes. Targeted prevention for children and young people should be considered alongside the provision of parenting programmes and should be addressed in the context of emotional health and wellbeing.
- Prevention has moved away from the three levels of prevention and is not multidisciplinary. The programmes designed have been given a negative feedback across Northern Ireland as too teacher based and not interactive enough. 2, one to one sessions are easily accessible without a long waiting time, receiving negative community feedback. There needs to be a more visible and immediate service, complimentary of existing service delivery. Varied services should be delivered to meet the needs of the young person and family. These should be services such as mentoring, work skills, mental health support, education support, a holistic and journeyed response. Support should be offered to families on a crisis basis.
- Not a clear linkage between tiers and levels of service. e.g. poor cross referral between targeted lifeskills programme and youth treatment, also between non PHA services and PHA funded services. Clearer pathways and linkages between services is needed e.g. Lots of people have

been trained to use Regional Initial Assessment Tool for young people but it's not utilised across services. More therapeutic family interventions capacity would be beneficial for more complex families. e.g. systemic family therapy. This could be achieved by enhancing systemic practice capacity in services like DAISY or enabling services to buy in systemic therapy support for cases. Need for flexibility in services to engage clients for longer period. High rates of non-engagement by young people in treatment services. Can often be because of poor preparation of young people for engagement or poor co-ordination between services supporting the young person.

- Service provision across Mid Ulster is disjointed as there are 2 provider working in Mid Ulster. Mid Ulster district should be covered by one provider to ensure continuity and equitability across the district.
- Flexibility for counsellor to return later that day or another day, if the young person doesn't feel up to attending the appointment
- CAMHS saying its alcohol related and passing to another service while the other service says it's a mental health issue and tries to pass back again. Young person not fitting into either service.
- Not visible enough.
- While waiting for someone else to make a referral more harm is taking place. Make someone or some organisation responsible for going out and working with existing services to identify those at risk and give them resources to do the work needed.

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

- There is a glaring need to strengthen the working relationship between mental health and addiction services. We see very few examples of community mental health services working as partners in the support/treatment provided to those experiencing mental health and substance use problems. Furthermore the community/voluntary sector is very active in picking up referrals from statutory agencies and for the benefit of service users, but this needs to happen both ways. The sometimes lengthy wait to be picked up for example by addiction services is when we see people present to our crisis project numerous times. The key points here are the need for responsibility sharing, not avoidance, and fluid movement across the statutory/voluntary sectors and mental health/addictions services. GP practices could be more aware of Low Threshold Services in order to make referrals to them where it is unlikely that the patient will engage with a CAT, or has failed to do so in the past, or has done in the past but without benefit. Young people leaving care require a service which engages with them at the earliest opportunity in relation to substance/ alcohol use and mental health concerns. This service should replicate that if the Aftercare service which would allow for meaningful engagement up to the age of 25years. Within an such service, harm reduction delivered via an assertive outreach model could support young people who often become homeless very swiftly after turning 18, at which point individuals have to navigate through Adult services which often have lengthy waiting lists and have unrealistic expectations of young people, for example SPT.
- Links between mental health/ suicide prevention and drugs and alcohol should be strengthened: Consideration should be given to the amalgamation of local PLIG's and DACT's. This would ensure a more joined up approach and enable the best utilisation of resources. As both agendas are relevant to many of the same stakeholders, this would also avoid duplication of effort on the part of staff. For low threshold services there is a need for closer working with mental health to ensure a holistic person centred approach. Access to individual / group based counselling should be available to those in low threshold services who wish to avail of it. Counselling services should sit within the context of the stepped care model outlined in the regional mental health care pathway. There is need for appropriate referral pathways between services particularly for those individuals with a dual diagnosis. Regional work in relation to ACE's and Trauma Informed Practice should be embedded within key services and with key professionals and evidence of training in these areas should form part of minimum standards for commissioned services.
- The services fail to work together, and competition exists for funding or notoriety. A more collective approach needs to be in place. Statutory services especially councils are very poor at engagement with community voluntary organisations. Other slowing or stopping progress. Statutory focus has moved towards the complex cases and have moved away from prevention and early intervention. Local funding focus has favoured larger organisations and left grassroots organisations without funding support.
- These issues have been explained above, but in general a better linkage between adult step2 and CAT and young people step 2 services e.g. youth treatment services being involved in supporting young people whose parents involved in adult treatment services, also providing support in relation to Hidden Harm. Better working arrangements between youth treatment and CAMHS. Also better pathways with adult addictions and mental health services, since youth treatment supporting up to age 25.
- Yes, I feel that more communication - Flyers etc on Services would encourage our YP to avail of the support available.
- Better communication between services and dual working with community and voluntary services.

- Yes, they need better links into existing community structures.
- GPs, PSNI and existing services; stop letting out-dated and overly red taped referral procedures allow professionals to pass the buck.

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

- Commissioning now before the strategy is finalised seems premature and creating uncertainty when Covid-19 is making everything uncertain.
- In general there needs to be faster access to services for YP with dual needs of mental health problems and substance use problems. We acknowledge the quality and benefit of these services, but access remains an issue. In general there should be more rapid access to drugs/ alcohol treatment; able to respond when motivation levels to change/engage are high. Contracts should be a minimum of 5 years with the possibility of yearly extensions to a maximum of 10 years. This would allow for flexibility to meet emerging needs but maintain stability in the organisation providing the service(s). Stable organisations lead to stable service provision, staff with job security and better outcomes for service users as a result.
- In order to ensure the effectiveness of prevention based approaches and to target those most at risk, baseline data and service user profiles across all services should be routinely collected and collated. Regionally consideration should be given to embedding routine assessment for substance and alcohol misuse within delivery of primary care and other HSC services to support early intervention and signposting to support services.
- The community support model that focused on intensive support was more effective and supported young people. This has been a big loss and should move back towards this model.
- The current services should be kept in place and developed to improve their capacity and effectiveness to meet needs. New services should not be procured until there is a comprehensive strategic commissioning model to support the delivery of the substance use strategy. The Stakeholder engagement process undertaken did not ask for views on the proposed commissioning, however there is a strong view across providers and other stakeholders that re-procurement of the current services should not take place before there is an agreed substance use strategy and should happen as part of a comprehensive commissioning model driven by the strategy.
- Very concerned about the 'cart before the horse' scenario currently employed by the Public Health Agency (PHA) which will impact upon every client we represent. It would seem this 'cart before the horse' scenario has been driven by a legal requirement on a Corporate Risk Register rather than based on the tenet of providing effective services to meet the ever increasing complex needs of service users in Northern Ireland. Co-design and co-production of services has been a long-desired and acknowledged requirement in the development of our next commissioning framework. Having taken part in some of the pre-engagement sessions it would appear PHA are not seeking to change their approach significantly or fundamentally with respect to the current delivery of services through this exercise. It appears more a straightforward re-procurement of current services. The purpose of their engagement is more to identify what minor changes need to be made now and not on how services. The voluntary and community sector acknowledges the risks and governance around procurement. However, there are also major risks in moving forward without recognising the following: TIMING • Timing issue - two consultations being undertaken, the first for the SUS, which opened on Friday 30th October 2020, and the second for the Regional Commissioning Framework for PHA Services which commenced on Thursday 15th October 2020; • The Commissioning Framework should fundamentally support the strategy rather than the other way around, as is currently planned; • The primary issue remains the Strategy has not been consulted on, and providers are currently attending pre-engagement sessions on the Regional Commissioning Framework with PHA; • The substance use strategy needs to lead the way not play catchup. IMPACT OF PROCUREMENT • Procurement is a lengthy, complex, competitive, and unsettling process for our sector in normal times. COVID-19 delivery and resource issues will amplify all of this; • The timeline given – Dec 2021, is unrealistic for services. Current providers need to think about tendering, procurement and potential transfer of contracts. Behind all of this, staff have to deal with job uncertainty and service users unintentionally impacted, as a result; • In relation to tenders, this will have significant impact on organisations who may have to tender for a range of services; • Procurement can take up to 6 months and upwards to complete. This needs to be taken into consideration, in this, the most trying of times; • Start360 are not aware of any assessment of the last round and how it has worked or not worked, we need to learn from the previous commissioning experience. LEARNING FROM THE PAST • Feel we have not built on or learned from the past – awaiting the implementation of the strategy would be a great opportunity to get things right; • There is a concern around the Framework as PHA is looking at services currently commissioned and not what is needed moving forward; 4 • A concern would be the current gaps in services are not addressed and service users remain on long waiting lists as an ongoing direct result of the last commissioning round; • Consideration as to how we can access support for evidenced based projects developed over the past 6

years outside of commissioning framework and how repeating commissioning based on current services removes options for new evidenced-based approaches; • Services are continuing to learn through this pandemic. These lessons should determine service provision post-COVID. JOINED UP SERVICES • Engagement so far has pointed to the need for better joined-up services for those suffering multiple needs, such as mental health and substance use including a more holistic treatment system, providing patient centred care around the needs of the service users. We must choose the most effective tools to tackle this threat, which may require some changes in how we think about this problem; • There seems to be no reflection at what is happening at grassroots level, it is frustrating to see no sense of joined-up working; • Why is there only engagement around the PHA Commissioning when ongoing recommendations have indicated SUS and Mental Health strategies need to be more joined up? • The Minister has acknowledged the need for better joined-up services, 'Our engagement so far has pointed to many things we can do better, including the need to better join up services for those suffering multiple needs, such as mental health and substance use' (Minister's Foreword, SUS, pg.2). NEED FOR RE-PROCUREMENT • The Regional Commissioning Framework will need reviewed following the publication of SUS – this will be a complex piece of work which we estimate will take at least 1-2 years as it involves all parts of HSC, the VCS , other key partners such as Criminal Justice, public, service users and stakeholder consultation. It will also need to include the wider commissioning environment and the need for greater alignment across other linked themes such as mental health. The proposed will deliver the new Substance Use Strategy.

- Members feel we have not built on or learned from the past – awaiting the implementation of the strategy would be a great opportunity to get things right; There is a concern around the Framework as PHA is looking at services currently commissioned and not what is needed moving forward; A concern would be the current gaps in services are not addressed and service users remain on long waiting lists as an ongoing direct result of the last commissioning round; Consideration as to how we can access support for evidenced based projects developed over the past 6 years outside of commissioning framework and how repeating commissioning based on current services removes options for new evidenced-based approaches; Services are continuing to learn through this pandemic. These lessons should determine service provision post-COVID.
- In my experience of working with YP who suffer from addiction, there needs to be a more thorough type of support, such as Counsellor calling to see them, support with transport. Understanding if the YP is slightly UTI of a substance they can still talk about their feelings. Some YP can only open up and communicate when they are slightly UTI of a substance.
- This round of tendering should place a renewed focus on community support rather than campaigns. A focus on those young people in the at risk category.
- A lot of existing services are very good, and more needs to be done to increase awareness of these services. More promotion of who to phone and when. Ensure responsibility is taken on board by professionals, making statements like 'these people need to also help themselves ' isn't helpful or useful to someone who cannot in any way help themselves. They can hardly get through on a day to day basis and expectations of them working on a long term plan (even 3 months) is unrealistic and an excuse and a barrier to support.

RCPsych Response – Young Peoples' 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 of ten 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 of ten 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 of ten 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.

Part B: Adult Services

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

- Dual diagnosis services
- More use could be made of self-help on line that is on www.drugsalcoholno.info Tier two does not make as much use of brief treatment resulting in extensive waiting lists. Should brief treatment be a separate commissioned service? Lesions should be taken from the Alcohol and You Evaluation which demonstrated the benefits of separating these services Brief intervention should extend beyond primary care and line in with health literacy and making every contact count More link with mental health provision is needed by that I mean all MH workers should be in place to deliver alcohol brief intervention and the two strategies reflect the link between the two. The draft NDS picks up on long term recovery needs. The question is how some of these can needs be met.
- Waiting times on treatment service and support for when clients come out of treatment. Lived experience support workers.
- Lack of funding to deliver effective treatment for People who inject drugs. Waiting list of 9 months is unacceptable Lack of communication or connectivity between organisations lack of service user involvement.
- In relation to the needs of those using alcohol, a low threshold supported living unit/accommodation which was not time limited and that understood the complex physical and mental health needs of the client group would be invaluable. Our alcohol team have worked with a large number of alcohol dependent service users whose tenancies continue to breakdown as a result of loneliness and isolation (triggering increased use, withdrawing from social supports, poor mental health etc.), antisocial behaviour or inability to physically manage independently. Such a unit would have the required adaptations for those who needed it (telecare, wheelchair access), 24/7 staffing, communal areas, activities etc. Lack of needle exchanges in the Southern Trust area (only 3 in total – Newry, Armagh, Craigavon). No direct access referral to Community Addictions Team in Southern Trust area. Our LTS have to signpost service users to their GP, creates a barrier or a delay in support. Rehabilitation facilities which are strongly faith-based or utilise 12-step approaches should do more to improve the impression some service users have that the service is not suitable for them. There are people who do not fit these approaches and will not avail of them. Shared care facilities in GP practices need to be provided in all 5 Trust areas. Low Threshold Service satellite clinics could be provided within GP practices, in the same way that CATs routinely do. Specialist services hosting satellite clinics within Low Threshold Service e.g. liver function testing, COPD, BBV vaccination, testing and treatment – taking the service to the service user where it is likely that they will not engage with these services otherwise. Upscaling of harm reduction approaches e.g. enhancing the PHA-funded Low Threshold Services. Rapid access to OST and other relevant treatments which are currently only provided by the Trusts. Partnerships with the Trusts to provide OST and other treatments in the future. Up-scaled specialist support for those with a diagnosed (or assumed) dual diagnosis. It is notable that many with the most severe substance use and mental health difficulties receive no services appropriate to their complex needs. This group are very often 'held' by homelessness services and prisons, with no responsibility taken for them by mental health services. Provision of intranasal as well as IM naloxone to organisations and individuals where there are difficulties in using IM naloxone or the need to inject it creates a barrier to carriage. We are not aware of any work to investigate the causes/drivers of ever increasing polydrug use in NI and a strategy to tackle it and the associated risks. There is no mechanism to look at the specific and underlying causes for escalating drug-related deaths in NI, such as there are in Scotland and Blackpool. Operational groups including (but not limited to) drugs services, police, coroner, housing agencies (including Supporting People and NIHE as well as service providers) and HSCTs should review each suspected drug related death and 'near misses' to develop a fuller understanding of the matter/issue and what can be done at local level to prevent more deaths from following. Learning from such a mechanism could be shared across all relevant sectors and organisations.

- Gaps in service provision include

• Difficulty in some areas accessing step 2 services due to service capacity • Referral pathways to step 2 services not utilized to their potential by primary care • Step 3 remains a blockage for clients more suitable for step 2 interventions • Family support not being provided in all areas and underutilized/offered • Brief interventions/Brief treatments not offered, low provision in some areas, and

services not therefore effective in reaching population at earlier stages of use/problems • Co-existing mental health issues commonplace but service provision restricted in step 2 services and poor pathways with mental health services • Lack of integration with young people's services for family support and Hidden Harm work • Not enough focus on recovery and relapse prevention.

- Referral pathways can be a barrier for service users. Broadening the scope for community agencies to be able to refer to to CAT. A dual diagnoses approach throughout Northern Ireland is required. Shorter waiting lists from referral to being assigned counsellor within community addiction teams. Short waiting lists for substitute prescribing programs. More funding for on the ground services such as harm reduction support. Addiction support being available via GP surgeries. Dual diagnoses treatment centre's which include detox facilities.
- Families who live with an individual with substance misuse issues, often lack clear information from a central source on navigating the pathway for supports in their locality and lack understanding regarding the interface between statutory and community and voluntary services, e.g. there is a need for greater collaboration between statutory and voluntary services and support for families to navigate the stepped model of care. E.g. when there is a need to speak to statutory services within mental health services if person goes missing or they have serious concern about their welfare. Sometimes it is apparent there is a lack of knowledge as to where the carers can get support themselves given the impact on their mental health of cumulative high stress levels. There is a lack of a proportionate level of training for substance misuse practitioners in assessing and treating trauma, which underlies most addictions. I also feel there needs to be clear support for commissioned services as there is concern that at times they are working with a level of complexity which meets the threshold for involvement in statutory services. If PHA funded services had the option to request a consultation to get advice this might be helpful.
- Short staffing.
- Services for the 50+ age group.
- What PBNI perceive as the current gaps in the existing services are the concerns with GDPR, and people seeing this as a barrier to provide information in some instances. This can be hard to co-ordinate with getting hard to reach clients in and to sign forms etc. Sharing of information and lack of Service Level agreements being implemented between some services. GP's can be the gatekeepers of services such as Community Addiction Teams – prolongs the waiting times for clients who can be reluctant to go to GPs. Waiting times for Opiate substitution treatment in Belfast particularly long compared to other areas in the UK. Also disparities between the different Trusts within Northern Ireland – Postcode lottery. Lack of rehabilitation/ detox beds in the Trust areas. Training needs - Harder to acquire training specific for those working within addiction services and not for general workforce populations. Lack of workforce training for heroin and crack cocaine that does not incur a cost.
- Inequality in Dual diagnosis services across all trusts Discrepancies in criteria Consultancy/Training Vs practitioner service delivery model No strategy Under resourced area Lack of clarity regarding who manages service- addictions/Mental health Definition of Dual diagnosis differs in CV/statutory sector No defined DD service in C&V sector however aware some level of service being provided
- Further development of community and voluntary service provision is required. Relationships require development between statutory and C&V sector.
- No availability of a floating support harm reduction or low threshold service in Belfast trust. No assertive outreach services either.
- Referring on to a service has to be done via the GP. Harm reduction service within the southern trust area is limited, and there is a long waiting list, meanwhile the service user is falling in to crisis. There needs to be more services available in the interim supporting the client.
- Need more resources going to dual diagnosis out of hours doesn't always have to be delivered by Statutory sector.
- Language barrier for BME communities accessing services, particularly mental health and support for addictions.
- ARBD services are insufficient
- Waiting times for referrals. Too long a gap between community involvement and stat pick up. More available and easily accessed dual diagnosis workers.
- Limited low threshold or early intervention services in Belfast trust area compared to other trust areas. I can get support for someone if they are using heroin or alcohol, but not if they're using cocaine for example. We need a low threshold service that works with all drug use.
- Women only focus rather than mixed group approach.
- Poor residential facilities and linked back up therapeutic services to address addiction.
- Community based Detox programmes.
- We have been campaigning for years to get commissioners to realise the inextricable link between drug and alcohol addiction and mental health issues. The two shouldn't be separated and this has been discussed for years with Trusts PHA and Councils. We hear talk of the principles of co-production in Delivering Together 2026, but this does not seem to be taken on board in this exercise. We have had promise after promise that PHA will look at both issues together but where is it this time around?? This looks like the easy and fast option just to get the service retendered and you know fine well it is broken as it is presently. If you do not know this already, you have not been listening to us over the years.
- There is a need to finally address the requirement to

connect addictions and mental health services. One does not exist without the other and cannot be treated differently.

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

- Low threshold services have been excellent Drug referral scheme with PSNI Family support as a dedicated commission service. While there is low uptake (a common experience world wide) the model the southern trust has used has dealt with this and it is integrated family support into tier 2 & tier 3 work. A gap is while services were trained to deliver an evidence based intervention more work is needed to embed evidence based work in family support.
- Service user involvement and different communities' groups for clients to attend when discharged from treatment.
- Staff tend to be excellent Drug outreach team are outstanding.
- There are excellent examples of good provision and practice across addictions/support services and other sectors such as housing support/supported accommodation, primary care and criminal justice. The recent addition of the Belfast Health Inclusion Service is strongly welcomed. When these systems link well and work well together it is always as a result of there being effective and positive working relationships across these arenas. Knitting them together then maintains those relationships – this can be fostered by tasking them to co-produce guidance, a presentation, research etc. with the intention of ensuring collaboration. Low Threshold Services outreach model is working well, engaging people where they are at. In some areas links with OST – the ability for our team to complete direct referrals, removing barriers and enabling service users to access services quicker. Naloxone provision has expanded well since LTS are able to provide it to service users and relevant others. Provision of needle exchange via LTS as well as community pharmacies and CATs. LTSs are in a position to offer specialist advice and guidance on safer injecting and use of foil. Whilst many professionals in the C &V sector have referenced the need for Dual Diagnosis Support, we already have an example of this within Extern. This is a two person team who, although hugely oversubscribed, work intensively with individuals who present with acute mental health issues in combination with substance and/or alcohol dependence. The support offered by the team is often long term (2+ years) which allows a mutually respectful partnership to develop and therefore engagement with relevant services, advocated for by the team. In many cases, the service user can access benefits, accommodation, medication and stabilisation in terms of mental health issues and co-existing addictions. This model is received very positively by funders and service users and has supported many individuals who would otherwise exist in a chronic homeless cycle to move away from this towards stability.
- All services appear to have good reputations and there is confidence in them. Having a reasonably consistent model of services across the region is a real positive. Services have well established relationships and have developed these over the past 5 years. Outcomes from services shows they are having an impact. Connections service • The connection services have been very effective in forging links with local communities and partnership with stakeholder. They should continue to have a role to support the local implementation of the substance use strategy in the community, promote prevention, collaboration and access to services. • The community responders initiative has been promising and could be scaled up to build capacity in the community workers, youth worker, volunteers to signpost to services through roll out of community responders training and develop into a network of community based support. Workforce development training is being provided across the region and there is a good take up. Step 2 services have a high demand and the linkages with CATs has improved over time. Providers have good levels of co-operation where that is possible.
- In some sections good working relationships between services.
- The compassion shown by so many staff is to be commended.
- Counselling services and giving organisations 5 year funding.
- Good working relationships and partnership working happening between statutory/voluntary and community sectors. Many staff in services go above and beyond to help those clients most in need. Low threshold working that some services provide is very beneficial. Needle exchange services are positive, but should be more wide spread. The response to the changing drug profile in the Belfast area and services are adapting to meet needs as best as they can – however training in the "newer" drugs and how to response definitely needs implemented. Harm reduction techniques that have been applied by services are beneficial and can be completed both via a brief or a longer term intervention. Service User Involvement important going forward.

- Impact of Alcohol funded by Big Lottery worked well in some Trust areas by connecting services and joining up the dots.
- Extern are fantastic and Simon community in set.
- Contact with client by outreach services.
- SDACT model.
- At present clients haven't been able to avail of all current services.

- Community detox teams and inpatient rehab facilities.
- Communication between services has gotten much better over the years. Collaborative working relationships between trust services and communities are vital for a safer more robust outcome for our services users.
- The level of support clients get from the voluntary sector.
- Outreach and ongoing, rather fixed term, support and group.
- Intervention for misuse of substances however same service inadequate for maintaining abstinence.
- OST clinic input appears to work well.
- When commissioners listen to people using services and the organisations on the ground providing those, it works. If you don't listen, it does not work - simple as...
- The service is good, if you do not have co-existing conditions.

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

- I think this is important. The guidance is step 2 service is that it should be accessed by people scoring under 20 on the Audit questionnaire. While the Audit questionnaire is the best screening tool in primary care it should be a guide not an absolute cut off. What we learned through Alcohol and You is many people will score over 20 but not see themselves as dependent. A score of 20 coupled with repeated withdrawal is better guidance for the referral pathway to Tier 3. The pathway should include client choice and self-help (alcohol and you self-help or cannabis and you self-help) in the menu of options How we get people to the right support at the right time may help with the waiting list dilemma. Also if step 2 services put more emphasis in brief treatment with MI as opposed to counselling for everyone it will help immensely (I think).
- More work needs done with the referral pathways into services and the step up/step down of services. They are inconsistent across the region. Combining substance misuse liaison in hospitals with mental health provision.
- Better education, training and funding. Look at successful models in other countries for inspiration like Portugal.
- While the wait to access tier 4 services does give time for supports to be put in place and preparatory work to be undertaken, there remain too many steps to take to get there. Typically starting with GP referral, CAT appointment, initial assessment, longer term worker, assessment for readiness for tier 4 service, then waiting for tier 4 itself. These steps do not reflect what we know about the timeliness of service provision when motivation levels are high. The Step 2 service provided by the Southern Trust; due to the distance many services must travel to a Community Addictions facility. They are therefore unable to engage in those appointments. Step 2 in other Trust areas is based within the community. Co-locating and providing the Step 2 service alongside the Low Threshold Service would reduce waiting times and increase engagement rates.
- We wouldn't say that services have not worked well, but there are areas where they can be more effective, and where there the environment could improve. Connections: The community responders initiative could be scaled up to build capacity in the community and develop into a network of community based support. Workforce development. • A strategic approach to workforce training is needed to guide development and targeting of programmes and follow developmental needs • Develop skills in other frontline services (inc drug and alcohol services) to support assessment, signposting and interventions. • Tiered training – introductory, intermediate, specialist. Focus on skills training and online/eLearning • Should be training for community, parents, service users. Skills based training , not just awareness, supporting with skills they need to support their loved ones, themselves Hidden Harm • Stepped care model for Hidden Harm needed so a pathway of support needed across the tiers and across adult and young people's services. Family support • Adult and young people treatment services should continue to provide family support. There needs to be a greater focus on family support in adult step 2 services in order to support he family members themselves and also to strengthen linkages to young people's step 2 services to support the needs of children in the family and to also provide a stepped care approach for Hidden Harm across the services. • Campaigns needed to promote uptake of family support in services. Family members see the needs of the person with the problem, not their own needs, or the role of family as a support. • More definition needed for a range of evidenced approaches to supporting families o Informal/structured family support of Supporting family member's needs (5 Step Method/Craft) o Engaging family in the treatment/recovery process (Systemic Practice/ Couples Therapy/Solution Focused Brief Therapy) o Consideration should be given to a standalone service for therapeutic family support that step 2 and 3 services can access as a further complementary support for their clients. Treatment services • The focus of service models needs to be on client outcomes and not restricted to numbers of sessions. Flexible delivery models, scope for longer intervention based on need • There is a need for more formal step up and down processes, within a more integrated system as the numbers stepping up and down between step2 and CAT is still minimal. • Include supports for mental health in drug and alcohol services. UK Guidelines on the Clinical Management of Drug Dependency63) are clear – no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, they should work collectively together to address the issues

and clients should not be referred back and forward between services unnecessarily • Step 2 services need to have a greater focus on brief treatment/extended brief interventions and targeted to reaching people at the stage of hazardous/harmful drinking and drug use. In some areas brief intervention delivery is virtually non-existent, with the delivery model being mostly counselling. Whilst many clients referred have significant or complex issues MI focussed brief treatment can be at least as effective as psychological therapies and would support services to be more effective as an early intervention and where clients are not ready or suitable for more structured intervention. This needs to be supported by pathways and marketing in primary care and the community to engage people to step 2 services at an earlier stage. • Promote service uptake by women and also family members, systemic approaches to engagement • Naloxone provision should be included in tier 2 services • Client support pathway for clients that move across trusts • Trauma informed practice promoted in service models • Dialectical Behavioural Therapy should be available • Holistic (body based) therapies should be available • Models should include wider social support through keywork and peer support (peer navigators?) • Relapse prevention and recovery supports should be included in service models and clear pathways to further recovery supports • PHA should fund an online recovery resource/app all services can access

- Referral pathways. Funding for on the ground services community services enhanced and maintained.
- There needs to be greater access/capacity for inpatient addiction support.
- Joint working with adult mental health service.
- The Drugs & Alcohol Forums are properly attended and no real structure to them. Not very effective and the meetings were just a talking shop. PHA should have monitored this more closely.
- Low threshold working is required throughout the services commissioned to provide Opiate Substitution Treatment (OSTSs.) Drug Outreach Teams provide this and from experience it works well with injecting drug users. Support required by other services to keep people in receipt of prescriptions from OST once obtained – perhaps a separate service. Having to provide "clean samples" to get onto OST prescription – this has had implications for some of our clients who were trying to withdraw themselves but still wanted OST. Mental Health and Addiction Services need a pincer approach – both things dealt with at the same time. Training for staff in relation drug related harms e.g. sex working, abscesses, safer sex, blood borne viruses and other sexual health matters. People going into hostels whilst trying to recover from drug/alcohol addiction is extremely flawed – safer "communities" need addressed and hard to tackle – some sort of abstinence accommodation would be beneficial.
- Lack of designated staff to address mental health and addiction issues in the C&V sector- Need for Funding for same- adequate training provision, resources required, partnership working/ communication with all services involved.
- Delivering services where people have to travel far from their own homes, this has exacerbated inequalities. Tenders going to large Belfast based organisations who found it difficult or couldn't deliver in more rural areas.
- Long waiting lists to get seen leaving support workers ,families to carry on supporting until appointment is arranged. The need for more harm reduction services on the ground supporting those until necessary clinical services are provided.
- Not enough out of hours Not enough investment into CV sector for non-residential recovery models.
- Clients that have been referred to GP for support due to Alcohol addiction, a questionnaire has deemed them not drinking enough/meeting criteria to get support/ medication beyond speaking with a nurse which is not what the client would like. Language barriers mean Counselling isn't always an option.
- ARBD services need to be expanded.
- Referral pathways. I do feel that community organisations need to be able to access trusts supports for our service users. And again how quickly those referrals are picked up.
- Again the lack of support for clients unless they are using 'more dangerous' drugs such as heroin.
- For clients, mainly in rural areas, going to an identified premise can be off putting as it identifies client with their problem.
- Short-term services in the community without residential component to ensure abstinence and address relapse n prevention.
- Needs to be more active fast tracked input/review for patients in the community following medical detoxes.
- As service users, we are constantly telling our story time and again to practitioners. This is tiresome and unnecessary. You need to bring providers and people who use services together and ask them how to make this better - this would be genuine co-production. As it is happening now, you are getting most people who you fund to come together to tell you how good or bad things are. How do you expect genuine engagement from people whose paymasters are asking them if services are right? They are not going to bite the hand that feeds them. This is not genuine engagement and should be widened out.
- The fact that there should be a 'no wrong door' approach to services. Mental health and addictions go hand in hand. You cannot expect one person to attend two services and tell their stories over and over again. How do you expect them to get well?

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

- Be more present in hostels and mental health facilities
- I filled this in but forgot something I think will be useful in a section below.
- Yes as mentioned above referral pathways and step up/ down provision- waiting lists need addressed and not simply by increasing staff but looking at model of delivery.
- Mental health and addiction service being recognised as one.
- All of them. Currently services are seen to compete.
- The links between statutory mental health and addiction/ support services are as poor and ineffective as ever, the separate silos rarely integrating for the benefit of those who need a holistic approach to their treatment and support. An integrated service model, delivered with more flexibility, which does not exclude those that need it would be the ideal.
- It would be helpful if there was a clearer picture of how the services sit within an overall service model across the tiers and that includes statutory services. We have already referred to the need for better processes between step 2 and 3 services and adult and young people's services. Better co-ordination and pathways are needed between addictions and mental health.
- More collaborated work and information sharing. Improved professional respect and trust for the community sector. Service accessibility.
- Greater links with Psychology /Regional Trauma services/ services to support perpetrators of CSA/services to support survivors of Child Sexual Abuse - greater links between adult and children provision - vulnerable children become vulnerable adults. In line with the science of the adolescent brain services for young people should consider extending provision to 21 in the first instance. Merging Protect Life suicide prevention with Drugs and Alcohol Service planning would enable to a more coordinated response to supporting people who are experiencing emotional pain and distress. Ensuring that all policy is embedded in a trauma treatment framework will enable practitioners to be proportionately supported in terms of trauma training, supervision and that a trauma informed workplace culture is given due focus. (A stressed therapist cannot regulate a stressed client.) We need to continue to raise awareness of the root cause of addiction issues ("Addiction is not a choice it is a response to emotional pain" Gabor Mate) and support our communities to respond with a more compassionate narrative. How do we promote key messages that the first question we should think of is "Why the pain?"
- Yes, no dual diagnosis worker in Belfast trust and service users cannot access support for their mental health if substances are used to cope with symptoms
- All groups. This is the role was of the co ordinators of the Drugs and Alcohol forum and they failed.
- Peer to peer training and mentoring for service users essential in the continuation of services. Diversionary training and activities so that people in recovery feel connected to others and feel fulfilled within their lives need developed – this has been a major gap during the COVID – 19 period. Also for over 30's – less variation of what is available. And specific target groups – e.g. women over 30 with addiction issues – onward services to refer into are limited which impacts recovery.
- Yes there is an opportunity for the development of more lines of communication with C&V and statutory services to benefit service users and service user groups.
- Links and connections need to be strengthened to efficiently use our limited resources. This area is sometimes undervalued or not recognised. I my opinion this is a highly skilled strength which takes a lot of experience and requires to be funded appropriately rather than giving a small amount of funding to inexperienced individuals who try their best but only touch the surface.
- Yes, if referrals could be made by all agencies. Some common ground with sharing information.
- Bi lingual support beyond just a telephone translation service would be beneficial. In terms of addiction support it is beneficial if clients can speak in their mother tongue with a face to face service. dedicated multilingual workers would strengthen this service.
- Between community services, general practice and secondary care.
- As above - opening the referral pathways and up skilling employees to deliver a more dual diagnosis approach. Good intervention services will help stabilize prior/ during the therapeutic treatment i.e., CAT, Trauma, psychotherapy etc.
- Yes - new MDT team in primary care in west Belfast need to be better connected in with the C&V sector, and more involved in stakeholder events as well. New service and support and more than willing to work with our C&V partners.
- Yes. This type of service NEEDS to have a linked, cooperative and partnership approach.
- Residential and transitioning to follow up therapeutic to maintain abstinence. Services need consistence and continuity of treatment as addiction requires long-term not shirt term temporary fix.
- Acute care and community needs strengthened.
- As above, don't know how many times you can ask us this, but there needs to be a genuine acknowledgement that addictions and mental health go hand in hand. You cannot treat one without the other and therefore should not be planning services in isolation from one another. service provision follows the money and if the money is directed down two parallel tracks, then there is only one possible outcome, two separate services for a connected issue and people falling through the cracks in the middle!!! But we are sick telling you this.

- Yes - between addictions and mental health. Both need combined they cannot exist in isolation.

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

- How do we more to a more trauma informed way of working, explore the emerging evidence of medication including psychedelics. As I said in the young people's response recommission now seems premature before the new strategy is finalised.
- That doctor, consultants don't see addiction as a mental health issue and treating both as two different illness.
- Meaningful and holistic service user involvement is essential. Providing services that address multiple complex needs and do not withdraw on the basis of complexity. We need to address the trauma which feeds the dependencies, so provide access to therapeutic support as well as peer mentoring to assist medical withdrawal or detox and make it effective.
- Contracts should be a minimum of 5 years with the possibility of yearly extensions to a maximum of 10 years. This would allow for flexibility to meet emerging needs but maintain stability in the organisation providing the service(s). Stable organisations lead to stable service provision, staff with job security and better outcomes for service users as a result. Flexibility within the contract i.e. allocating funding with overarching themes as opposed to specific numbers of clients, interventions and targets would encourage reflexivity and pragmatism in service delivery without the delay of returning to funders to request additional monies. Where frontline staff identify a trend or theme amongst the client group, a flexible contract would allow for immediate response. Outcome based reporting to PHA would allow for a clearer and more genuine overview of the success of service provision. However we should avoid and learn the lessons from the failure of 'payment by results' in GB over the last decade.
- It is our view that the reprocurement of the PHA services should be delayed to allow for the development of a strategic commissioning framework that would include the PHA services. This is intended to happen as part of the new substance use strategy but the PHA has chosen to re-procure services in advance of the strategy being agreed and the development of a framework to deliver the strategy's outcomes. The PHA did not ask in the stakeholder engagement process for opinion on their approach to procurement and we are taking this opportunity to urge that existing services are continued and developed to better meet needs, until a strategic framework for commissioning is in place as we believe this will lead to a better and stronger configuration of services.
- If no joint working with mental health services, the underlying trauma/mental health symptoms cause relapse of use, so cycle never breaks.
- Public Health Agency should provide longer term funding even up to 10 years. It takes 2 - 3 years' time to establish a project and then the project finishes. This is extremely difficult for the long suffering community organisations who have to tolerate Public Health Agency high and unrealistic expectations. PHA don't take into account the impact of the uncertainty of funding on community sector staff.
- This is an exciting opportunity to improve services and get things right by learning from the past. A more community focused approach with small funding opportunities in each Trust given to organisations with a proven track record of delivering in the area will work better.
- There are families left picking up the pieces due to people presenting but falling between gaps, that needs urgently addressed Need to stop doing things the same way expecting different outcome. Lack of safe places for IDU, lack of safe space i.e. Wet House instead of person going back into the care of families Investment into family support not clinical provision.
- As a support worker, I find that several GP surgeries that have receptionists from other countries are able to support client well as they feel more empowered when they can converse and express their issues in their own language.
- I am part of a crisis team working with individuals experiencing suicidal thoughts/behaviours. A majority of these individuals are using substances as a way to cope with deep rooted (at times) trauma. Current situational stressors are a trigger and risk taking behaviours heighten. We are experiencing a heavy referral intake for a team of 2.5 people and we find that we are 'holding' due to the waiting times of referrals for trust treatments. Step up step down approach with shorter waiting times would be ideal.
- It is crucial that trust and confidence is built up and retained between service providers and users; and that there is ongoing long term support especially through client support groups/users. The service also needs to be

accessible 24/7 as addictions are challenged at all times. Further, there needs to be an opportunity for women to have access to additional women only support to meet the specific needs of women recovering addicts such as them trying to retain and keep a family.

- Addiction is not developed through short term misuse but prolonged use . The nature of addiction requires long term intervention n family input.
- Please listen to people using your services and have the courage to change when people plainly tell you existing services are not meeting our needs. Please do not come on and explain that you are 'legally required' to renew contracts and 'procurement issues' mean we have to do this and get services extended while we wait on a strategy that might be years away. You are also 'legally required' to include PPi in service design and proper PPI at that. Your Department talks about 'Co-production'. This is easy to say, not so easy (or quick) to do, but you have a commitment to address it. At the start of your presentation you curtailed the opportunity to open a proper conversation on the real needs of service users by saying the session was limited to existing services only. We all know how long the new strategy will take so issues need to be fixed now not in 5 years' time.
- For years we have been campaigning to bring addictions and mental health services together. a 'NO WRONG DOOR' approach. This consultation ignores what service users and politicians have been asking for years.

RCPsych Response – 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 suggest 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 requires 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. Tier 2 & Tier 3 in NHSCT have regular meetings to discuss referrals and have noted that there is often a duplication of referrals across tier 2 & 3. A single point of referral would enable the individual referred to be directed to the most appropriate service at point of referral and prevent duplication of assessment process when moving between services.
4. The separation of funding between drug and alcohol services funded by PHA and those commissioned by HSCB results do not support 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 are funded by PHA and are not commissioned through statutory addiction services with the result that smoking cessation is generally not addressed with 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. The low threshold service within the NHSCT has been extremely beneficial in engaging with harder to reach service users who are using opiates but who are not yet ready to engage in structured tier 3 OST services. This has enabled service users to remain in tier 2 treatment programmes until they are ready to engage with OST services.
8. Services for women who 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 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. A regional IMT would be beneficial when a service user moves between tier 2 & 3 services and across different trusts.
14. The effects of COVID-19 on access to treatment and how virtual technologies can be used to best effect
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?

1. Links between Tier 2 and Tier 3 service have improved with joint referral meetings becoming the norm. Tier 2 & Tier 3 in NHSCT have regular meetings to discuss referrals and have noted that there is often a duplication of referrals across tier 2 & 3. A single point of referral would enable the individual referred to be directed to the most appropriate service at point of referral and prevent duplication of assessment process when moving between services.

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

   The Stars project which assisted with the safe disposal of injecting paraphernalia in the community was a beneficial part of the Tier 2 service but unfortunately was withdrawn as a service earlier this year, consideration should be given to reinstating the service.

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.

This broad range of health and care professionals and indeed those working in criminal justice setting 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 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 to how best to engage with these groups

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.

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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
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3. *E-learning: A free e-learning aimed at supporting the Everyday Interactions toolkit*

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

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 (COMAD) have an increased risk of adverse outcomes. However it is very important to note that the care of people who have mental health and alcohol and/or drug use conditions so commonly co-occur that they are "everyone's business" who works in mental health or addiction services 1,2,3. Clinks1 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.[4]

The Department of Health (NI) should ensure mainstream mental health service has the core competencies to assess individuals with COMAD who not infrequently have a past history of trauma and 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 (COMAD) was not discussed within the Department of Health Mental Health Action Plan May 20204.

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."

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."

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

4. *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

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

6. 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

Recommendation
Mental health and addiction service must work together to bridge the gaps in patient care for those with COMAD. The Department of Health (NI) should ensure mainstream mental health service has the core competencies to assess individuals with COMAD who not infrequently have a past history of trauma and adopt the "no wrong door " approach which is supported by NICE and Public Health England

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.

(c) The need to improving 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 individual's 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

Recommendations
The Impact Measurement Tool (IMT) is currently being used to monitor outcomes across Tier 1 and Tier 2 drug & alcohol services 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 replace 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"

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

Recommendations

- 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

(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. NICE3 completed a consultation on quality standards on Fetal Alcohol Spectrum Disorder during 2020 which will require an improvement in screening and treatment for women who use alcohol during pregnancy.

References

1. *SIGN 156 Children and young people exposed prenatally to alcohol- A national clinical guideline Scottish Intercollegiate Guidelines Network January 2019*

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 Fetal 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*

Recommendations

a. 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.

b. All services for people with drug and alcohol problems need to have clear guidance on safeguarding both children and indeed vulnerable adults.

(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 is 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

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/

Recommendations

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 helpful to ensure the necessary agencies are able to address housing, social and care needs

(g) Encouraging Primary Care to become more actively engaged in the assessment and treatment of the 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 worked 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.

Recommendations

1. Clearer guidance should be available to GPs on prescribing and deprescribing on medications with an abuse potential, such as benzodiazepines, z-drugs, opioids, and gabapentenoids.

2. 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 has formed an All Party Group on Reducing Harm Related to Gambling - Inquiry Call for Evidence. This follows the closing of a Consultation on Regulation of Gambling in Northern Ireland held by the Department of the 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 problems 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.

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)*

Recommendations

"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 service for young people;

(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 user 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 outcome; 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 manage alcohol programme is an appropriate option.

> "Managed alcohol programs (MAPs) are harming 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 service would be helpful in reducing duplication of services and in ensuring the best use of resources

The interface between prison healthcare and addiction service 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 .to reduce the risk of dropping out of treatment at a time when there is a high risk of drug overdose.

Appendix 2 – Letters Received

Northern Ireland Alcohol & Drug Alliance

info@niada.net

Robin Swann, MLA
Minister of Health,
Department of Health,
Castle Buildings,
Stormont Estate,
Belfast

By email

4th November 2020

Dear Minister,

Re. **Procurement of PHA Substance Use Services in advance of Substance Use Strategy (SUS)**

NIADA (Northern Ireland Alcohol and Drug Alliance) facilitates co-operation among the voluntary and community sector organisations providing services for and supporting those affected by alcohol and drug use, and their families across Northern Ireland.

Our vision is to have a society where people affected by substance use have **access to the right services, in the right place, at the right time.**

NIADA's mission is to **work collaboratively to raise awareness and influence policy and practice** on the impact of substance use on individuals, families and communities.

Key purposes are to:

- Create an **independent** cohesive voice for the sector;
- **Advocate and influence** policy, practice and service delivery;
- Campaign for the voluntary and community sector **to be involved** in the development, design and delivery of alcohol and drug services;
- Provide members with **direct access** to PHA, HSCB and DoH decision making processes;
- Provide members with networking, information sharing and publicity **opportunities**.

Strengthening the VOICE of the Sector

ADDICTION NI
ARC FITNESS
ASCERT
CARLISLE HOUSE
DEPAUL
DAVINA'S ARK
DUNLEWEY ADDICTION SERVICES
EXTERN
NORTHLANDS
RSUN
SIMON COMMUNITY
START360
YMCA LISBURN

The membership is very concerned about the 'cart before the horse' scenario currently employed by the Public Health Agency (PHA) which will impact upon every organisation listed above and the clients they represent. We would also underline we are not coming from a place of self-interest as NIADA is entirely about making sure the best possible services are available for those who need them.

NIADA members also work very closely with PHA colleagues and enjoy a high level of co-operation and collaboration.

As you are aware, pre-engagement sessions are currently being undertaken by PHA on a commissioning framework for substance use services to commence in January 2022. This, in itself, is a laudable exercise. However, not when performed in advance of the new Substance Use Strategy (SUS), 'Making Life Better – Preventing Harm & Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use', which has just gone out for consultation.

It would seem this 'cart before the horse' scenario has been driven by a legal requirement on a Corporate Risk Register rather than based on the tenet of providing effective services to meet the ever increasing complex needs of service users in Northern Ireland.

Co-design and co-production of services has been a long-desired and acknowledged requirement in the development of our next commissioning framework.

Having taken part in some of the pre-engagement sessions it would appear PHA are not seeking to change their approach significantly or fundamentally with respect to the current delivery of services through this exercise. It appears more a straightforward re-procurement of current services. The purpose of their engagement is more to identify what minor changes need to be made now and not on how services will deliver the new Substance Use Strategy.

The SUS itself, on pg.67 - D4, states 'The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines.'

The proposed PHA commissioning will not deliver a change in approach, it will not be driven by meeting service user needs, and it will not deliver a strategic plan for commissioning as it is designed to continue the same set of services currently in operation and in isolation from the other actions and priorities described in the SUS and independent of the other areas of the commissioning environment e.g. Trusts, Justice, etc.

NIADA would ask - Is this, an effective use of time and resource, in the midst of a global pandemic, when the exercise will be required to be repeated post-Strategy in potentially one to two years' time?

The voluntary and community sector acknowledges the risks and governance around procurement. However, there are also major risks in moving forward without recognising the following:

TIMING

- Timing issue - two consultations being undertaken, the first for the SUS, which opened on Friday 30th October 2020, and the second for the Regional Commissioning Framework for PHA Services which commenced on Thursday 15th October 2020;
- The Commissioning Framework should fundamentally support the strategy rather than the other way around, as is currently planned;
- The primary issue remains the Strategy has not been consulted on, and providers are currently attending pre-engagement sessions on the Regional Commissioning Framework with PHA;
- The substance use strategy needs to lead the way not play catchup.

IMPACT OF PROCUREMENT

- Procurement is a lengthy, complex, competitive, and unsettling process for our sector in normal times. COVID-19 delivery and resource issues will amplify all of this;
- The timeline given – Dec 2021, is unrealistic for services. Current providers need to think about tendering, procurement and potential transfer of contracts. Behind all of this, staff have to deal with job uncertainty and service users unintentionally impacted, as a result;
- In relation to tenders, this will have significant impact on organisations who may have to tender for a range of services;
- Procurement can take up to 6 months and upwards to complete. This needs to be taken into consideration, in this, the most trying of times;
- NIADA is not aware of any assessment of the last round and how it has worked or not worked, we need to learn from the previous commissioning experience.

LEARNING FROM THE PAST

- Members feel we have not built on or learned from the past – awaiting the implementation of the strategy would be a great opportunity to get things right;
- There is a concern around the Framework as PHA is looking at services currently commissioned and not what is needed moving forward;

- A concern would be the current gaps in services are not addressed and service users remain on long waiting lists as an ongoing direct result of the last commissioning round;
- Consideration as to how we can access support for evidenced based projects developed over the past 6 years outside of commissioning framework and how repeating commissioning based on current services removes options for new evidenced-based approaches;
- Services are continuing to learn through this pandemic. These lessons should determine service provision post-COVID.

JOINED UP SERVICES

- Engagement so far has pointed to the need for better joined-up services for those suffering multiple needs, such as mental health and substance use including a more holistic treatment system, providing patient centred care around the needs of the service users. We must choose the most effective tools to tackle this threat, which may require some changes in how we think about this problem;
- There seems to be no reflection at what is happening at grassroots level, it is frustrating to see no sense of joined-up working;
- Why is there only engagement around the PHA Commissioning when ongoing recommendations have indicated SUS and Mental Health strategies need to be more joined up?
- The Minister has acknowledged the need for better joined-up services, 'Our engagement so far has pointed to many things we can do better, including the need to better join up services for those suffering multiple needs, such as mental health and substance use' (Minister's Foreword, SUS, pg.2).

NEED FOR RE-PROCUREMENT

- The Regional Commissioning Framework will need reviewed following the publication of SUS – this will be a complex piece of work which NIADA estimate will take at least 1-2 years as it involves all parts of HSC, the VCS , other key partners such as Criminal Justice, public, service users and stakeholder consultation. It will also need to include the wider commissioning environment and the need for greater alignment across other linked themes such as mental health.

The proposed process will cement inconsistencies and postcode lotteries that currently exist rather than addressing them. There is a case to be made for the acknowledgement of the evidence of efficacy for those projects being funded and those that are failing to meet the needs of the service users. There has not been any process of evaluation that could inform the procurement and highlight best practice models across the different areas – Low Threshold, Treatment, Young Peoples Services etc – creating a framework that details a consistent standard of delivery that can be delivered regardless of which organisation is successful.

Existing services should be supplemented/developed with additional resources to meet level of need and respond to emerging need until a comprehensive commissioning framework has been produced. This would be more practical and effective approach, allowing services to focus their energy on responding to community need at this critical

time, rather than diverting attention and capacity away towards premature commissioning.

'This past few months has been an extremely difficult period for the Health and Social Care sector and this has put a strain on existing services…It is now important that we learn from this experience and fine tune innovative ways of working (Minister's Foreword, SUS, pg.3).

NIADA would ask you to consider our concerns and would welcome a meeting to discuss further as a matter of urgency.

Yours Sincerely

Anne-Marie McClure
NIADA Chair on behalf of the membership

Cc: Richard Pengally, Permanent Secretary, DoH
Olive MacLeod, Chief Executive, PHA
Sharon Gallagher, Chief Executive, HSCB
Gary Maxwell, Health Development Policy Branch, DOH
Seamus Mullen, Health and Social Wellbeing, PHA
Maurice Meehan, Health and Social Wellbeing, PHA
Frances Dowds, Health and Wellbeing Improvement, PHA
Michael Owen, Health and Wellbeing Improvement, PHA
Colm Gildernew, MLA, Chair of Health Committee
Fergal O'Donnell, Insight Solutions

By email
Mrs Olive MacLeod
Interim Chief Executive
Public Health Agency
12-22 Linenhall Street
Belfast, BT2 8BS

1 December 2020

Dear Mrs MacLeod
The Drug and Alcohol Co-ordination Teams (DACTs) across Northern Ireland are partnerships of statutory, voluntary and community stakeholders that support the local implementation of the drug and alcohol strategy and promote collaborative approaches to respond to local needs. DACTs include existing PHA-contracted services among their membership, who may have a 'vested interest' in below, alongside the full membership's interest in the wellbeing of the local population.

As Chair of Southern DACT, I write on behalf of the SDACT to express concern at the Public Health Agency's proposed re-procurement of its funded drug and alcohol services by the end of 2021. Members of the SDACT discussed this concern on 25 November 2020.

In a strategic context where Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use (the 'Substance Use Strategy') has just been released for public consultation it seems premature that decisions on the services needed to support the delivery of the strategy would be taken before the final strategy has been adopted and before a comprehensive commissioning framework has been developed.

The proposed new 'Substance Use Strategy' includes an action that 'The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines.'

It is essential that services are designed in order to meet service users' needs within a whole system approach across health and other areas such as justice and education. Therefore it does not make sense that the PHA would engage a procurement process now that will result in the main drug and alcohol services being locked into a model until 2025-2028 (as proposed by PHA in its current engagement work) that will inevitably need to change in the next couple of years.

In the midst of an ongoing global pandemic, where there is evidence that the impact of the pandemic on our community includes increased risk and harm from alcohol and drug use, the focus should be on utilising resources and capacity in services to respond to community needs, whereas undertaking a cumbersome and time consuming procurement exercise will only put both the PHA and service providers under further unnecessary pressure.

This pressure becomes of even less value if the PHA proceeds with full competitive procurement but reduces the proposed contract term to align with the strategy being published.

We would strongly urge the PHA to delay the procurement of its services until a comprehensive commissioning framework has been designed that defines the service models needed across the commissioning bodies to implement the regional strategy and meet service user needs.

Until then the current services should be extended or renewed through direct award and additional needs met through service enhancement or the development of additional initiatives. We consider that maintaining existing services is part of the critical response to the pandemic and would be a justifiable rationale for the use of direct award contracts until the 'Substance Use Strategy' and associated commissioning framework are developed.
Yours sincerely,

Lydia Scholes
Chair
Southern Drugs & Alcohol Coordination Team

Olive MacLeod OBE
Chief Executive
Public Health Agency
12-22 Linenhall Street
Belfast, BT2 8BS

cc: Minister Robin Swann MLA; Dr Michael McBride CMO

30th November 2020

Dear Mrs MacLeod,

The Drug and Alcohol Co-ordination Teams across Northern Ireland are partnerships that support the local implementation of the drug and alcohol strategy and promote collaborative approaches that respond to local needs.

We are writing as Chairs of DACTs to express concern at the Public Health Agency's proposed re-procurement of its funded drug and alcohol services by the end of 2021

DACT members have contributed to the recent PHA stakeholder engagement workshops but only the Southern DACT has had an opportunity to meet, therefore this letter represents the views of the undersigned as Chairs of the respective DACTs. We understand the Southern DACT as a group separately.

DACT membership includes existing PHA commissioned service providers, however the views expressed in this letter represent our considered opinion as Chairs having considered the wider interest. In a strategic context where the Substance Use Strategy has just been released for public consultation it seems premature that decisions on the services needed to support the delivery of the strategy would be taken before the final strategy has been adopted, and before a comprehensive commissioning framework has been developed.

The new strategy, Making Life Better – Preventing Harm and Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use, includes an action that *'The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines.'*

It is essential that services are designed in order to meet service users' needs within a whole system approach across health and other areas such as justice and education. Therefore it does not make sense that the PHA would engage a procurement process now that will result in the main drug and alcohol services being locked into a model that will inevitably need to change in the next couple of years.

In the midst of an ongoing global pandemic, where there is evidence that the impact of the pandemic on our community includes increased risk and harm from alcohol and drug use, the focus should be on utilising resources and capacity in services to respond to community needs, whereas undertaking a cumbersome and time consuming procurement exercise will only put both the PHA and service

providers under further unnecessary pressure. This pressure becomes of even less value if the PHA proceeds with full procurement but reduces the proposed contract term to align with the strategy being published.

We would strongly urge the PHA to delay the procurement of its services until a comprehensive commissioning framework has been designed that defines the service models needed across the commissioning bodies to implement the regional strategy and meet service user needs.
Until then the current services should be extended or renewed through direct award and additional needs met through service enhancement or the development of additional initiatives. We consider that maintaining existing services is part of the critical response to the pandemic and would be a justifiable rationale for the use of Direct Award Contracts until the Substance Use Strategy and associated Commissioning Framework are developed.

Yours sincerely,

Gary McMichael (Co-Chair Belfast DACT)
Ed Sipler (Co-Chair, South Eastern DACT)
Kieran Brogan (Co-Chair, South Eastern DACT)
John Hunsdale (Chair, Northern DACT)
Liam Dunne (Co-Chair, Western DACT)

Appendix 3 – Breakdown of Stakeholders

NI Government Departments
Department of Justice
Department of Health

NI Government Departments
NHSCT
SET
SHSCT
BHSCT
WHSCT
HSCB
Northern Ireland Ambulance Service

NI Government Departments
Armagh Banbridge & Craigavon Council
Ards and North Down Borough Council
Belfast City Council

NI Government Departments
Education Authority (Youth Service)
PCSP
NI Prison Service
Probation Service NI
Youth Justice Agency
PSNI

NI Government Departments
ASCERT
Barnardo's
EXTERN
Start360
Simon Community NI
De Paul Ireland
Dunlewey Addiction Services
MACS Supporting Children and Young People
PAPYRUS Prevention of Young Suicide
The Find Centre
Community Restorative Justice Ireland
Addiction NI
Northlands
Solace
ARC Fitness
CWSAN
Glen Community Parent/Youth Group
Greater Village Regeneration Trust
Lower Ormeau Residents Action Group
VOYPIC
New Life Counselling / Action Mental Health
Carlisle House
East Belfast Mission
Forward South Belfast
The Welcome Organisation
Women's Information NI
Counselling All Nations Services (CANS)
Mindwise
The Resurgam Trust
Youth Justice Agency
Colin Neighbourhood Partnership
Impact Network NI
Alpha Housing
Triangle Housing
Northern Ireland Alcohol and Drugs Alliance (NIADA)

NI Government Departments
West Belfast GP Federation
Causeway GP Federation
Newry & District GP Federation
Derry GP Federation
Mc Keagney's Chemist

NI Government Departments

Area/Focus	Number of Responses
Young People / Community Services	12
Adult Services	28

Further breakdown as follows outlined below. Please note that some responses were anonymous and therefore the organisation submitting the response will not be listed below:

NI Government Departments
Health and Social Care (Statutory)
SET
SHSCT
Local Councils
Mid Ulster District Council
Community & Voluntary Sector
ASCERT
EXTERN
Start360
VOYPIC
Northern Ireland Alcohol and Drugs Alliance (NIADA)
MACS Supporting Children and Young People

Adult Services
Health and Social Care (Statutory)
SET
SHSCT
BHSCT
Royal College of Psychiatrists

Local Councils
Mid Ulster District Council

Other Statutory
Probation Board
Community & Voluntary Sector
RSUN
Another World Belfast
Extern
De Paul Ireland
Inter Ethnic Forum
WINT and Hope Centre

Appendix 4

PHA Drug and Alcohol Commissioned Tendered Services in Northern Ireland shown by Trust area

Commissioned service	Belfast HSCT	South Eastern HSCT	Northern HSCT	Southern HSCT	Western HSCT
Therapeutic Services for Children, Young People and Families Affected by Parental Substance Misuse	Barnardo's Northern Ireland		Start360		
Provision of Support, Care, Facilitation and Harm Reduction Services for People who are misusing Substances (Low Threshold Services)	**Existing services have been extended until the 31st December:** Belfast Drug Outreach Team (Provided by BHSCT) Alcohol Housing Support Service and Drugs Accommodation Support Project (Provided by Extern NI)	Simon Community NI	Extern NI	Extern NI	Depaul Ireland
Community Based Early Intervention Services for Adults and Family Members Affected by Substance Misuse	Addiction NI	Dunlewey Addiction Services	Extern NI	Southern Health and Social Care Trust (Community Addiction Team). Currently stood down due to Covid pressures	ASCERT
Community Based Services for Young People who are identified as having Substance Misuse difficulties	Start360		ASCERT	Dunlewey Addiction Services	ASCERT
Community Alcohol and Drugs Information and Networking Service	Extern NI	ASCERT	Start360	Start360	ASCERT