Northern Ireland Alcohol & Drug Alliance

27/11/2023

Dear Kevin

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.

NIADA members deliver the current PHA substance use services and/or represent service users and include:

ARC Fitness, ASCERT, Carlisle House, Davina's Ark, Depaul, Dunlewey Addiction Services, Extern, FIND, FutureProof, GamCare, Inspire, Leonard Cheshire NI, Lisburn YMCA, Northlands, RSUN, Simon Community, Smart Recovery and Start360.

We encouraged all members to respond individually and as a NIADA collective to the public consultation on the Substance USE Strategic Commissioning Implementation Plan. Feedback was received from ASCERT, Davinas Ark, Dunlewey and Simon Community from which we have collated for your information.

Regards,

Pauline Campbell

NIADA Chairperson

Prevention and Early Intervention

Members support early intervention as it educates and informs the person, bring about self-awareness that can create change. It can provide the right response when a person needs help and support. Effective specialist interventions that meet the needs of the people when they need it.

However, it should also be multi-faceted and not come from an abstinence-based approach at all costs. Early intervention does not require this and may seek to marginalise potential service users who may engage in such programmes.

Whilst NIADA recognises the commissioning actions as positive there are some issues.

Sp1-1. Is to be resourced within existing resources. The capacity of currently commissioned services is limited. We do not believe the recommissioning and development of therapeutic services can be achieved within the resources currently available.

There will need to be co-working with Social Services to recognise that the education provided by services are independent of them and as such cannot be dictated by them. It should also be recognised that referral to these services may not be voluntary by individuals for fear of issues relating to social services and access to children which can hinder any real therapeutic alliance between parents, children, and these services.

SP1.2. It is important to note that educational literature should be honest and real and not based on fear. Education around substances has proven to be much more effective than the idea of 'scaring people' away from the use of substances.

SP1.3. Specific definitions of brief intervention would be welcome and a uniform approach by statutory, community and voluntary services is needed. We must ensure the workforce is skilled in brief interventions in respect of substance use" – who does "the workforce" refer to? It should be available in all settings and across the public and voluntary sector workforce. Within Primary Care, Multi-Disciplinary Teams are ideally placed to have these conversations with patients and should be included in training.

SP1.4. Barriers of communication and inter agency working needs to be addressed. GDPR cannot be used as a reason for organisations/services to communicate/not communicate with each other.

SP.1.5. Commission evidence-based universal and targeted programmes for young people and adults that support healthy decision making and Health Literacy – why is this only referencing young people? Programmes targeting people at other ages should also be evidence based.

SP1.6. Community pharmacy should be looking to mitigate risk whilst also having direct link to C.A.T teams who prescribed Opioid Substitution. However more needs to be done on the reason why OTC medication is being accessed, for example is it pain management/ metal health issues? This needs to be viewed through the lens of the Biopsychosocial and not merely just substance use.

SP2.5. Building on the review of the role, function, and membership of the DACTs, develop the role of the DACTs as a mechanism for wider collaboration between local/ regional stakeholders. The review of DACTS is a significant piece of work and has not yet taken place, yet this is listed as a short-term action? What is the timeline for this?

SP 2.6. Strengthen the sustainability of services provided by the community and voluntary sector and review how the services are commissioned and procured through an ongoing review and assessment of models of intervention and evaluation of impact. It is unclear what is meant by this statement – while members agree that the sustainability of C&V sector services is vitally important, this statement doesn't explain how sustainability will be achieved. Also, this is listed as a short-term action, however review, assessment, and evaluation of models of intervention is a significant piece of work and has not yet commenced? This should include reviewing which funding streams have been cut or ended in recent years to give a picture of current provision and gaps.

The need for better support for people experiencing co-occurring issues was raised in discussions. The Action Plan and is referenced in the narrative sections of the document, but this is not reflected in actions. Only SP2-4 references this and is very limited in scope.

SP2.9. The community and voluntary sector is often excluded from information sharing arrangements to the detriment of people who use these services. Issues relating to information sharing. Arrangements need to be resolved for people using services to get the best service to meet their needs. A sharing protocol would be advantageous if implemented.

SP2.12. Enhance advocacy services and peer mentors in treatment and recovery services – does this mean the enhancement of these services where they already exist or the development of new services? As an organisation we agree with this approach, but current service models do not allow for this type of work – either because there is no resource to support this work or because the use of volunteers is explicitly not allowed. There should be an action committing to include this approach when commissioning to ensure it is embedded consistently and effectively.

Another area of concern is confidence in the ability to deliver the commissioning priorities with the available resources. There are 21 actions that will be delivered within existing resources and 27 that require additional resources. In many cases the actions within existing resources are to expand on existing services or develop new services. We would be concerned that the framework is not realistic in delivering these actions within resources and the impact that doing so would have on the quality of services.

Although we agree the commissioning actions for Strategic Priority 1 the commissioning framework should be more specific about which sectors and settings it will be extended to. It is our opinion it should not be restricted to primary care or the HSC workforce. It should be available in all settings and across the public and voluntary sector workforce.

Community and voluntary sector need to be an equal partner in conversations and not an afterthought.

Timescales need to be realistic and reflect the workload and resources currently available.

Pathways of Care and Models of Support

We agree that pathways of care and models of support should be included within the strategic priority plan. This should also include a consideration of trust boundaries where people are restricted to which support, they can avail of due to living on peripheries away from main areas of support in each individual trust. This particularly applies to rural communities isolated from main areas/town/cities in each trust.

The commissioning framework does not speak to its intentions in relation to low threshold services despite these being currently commissioned. The framework should include an action to recommission low threshold services.

Despite highlighting the importance of co-existing substance use and mental health issues in the introduction the only commissioning actions that are specific to co-existing issues is SP2-4 Review and reconfigure Substance Misuse Liaison Services available for people with substance use issues who meet mental health in patient services and acute general hospital services including emergency departments. The portfolio of substance uses treatment services commissioned for young people and adults should include a remit for supporting o-existing substance use and mental health issues.

We welcome this action and support the need to strengthen the sustainability of services. It would be useful of the commissioning framework spoke more directly to what this means in practice in the document itself or this action. Additionally, this action should extend beyond HSC commissioned services.

Commissioning actions are relevant with consideration.

SP2-4- The substance Misuse Liaison services have been significantly altered and does not resemble what they were previously. There is a distinct lack of knowledge in many of these teams regarding substance use. The schism that exists between substance use and mental health is often very evident within these services at present. There is also a massive disconnect between these services and the Community and Voluntary services and there seems to be an eagerness to refer without partnership working/information sharing (notable exception to this is the SE Trust Substance Misuse Liaison Team) who work to the highest standards with the Community and Voluntary Sector.

SP2-5- A need for more statutory sector involvement across all departments is required for the DACT services to be effective.

SP2-6- There needs to be longer contracts given out to Community and Voluntary sector to ensure development of services and retention of workforce. Current reporting systems do not reflect work being done and a review of current IMT/Reporting systems is required.

Strengthen the sustainability of services provided by the community and voluntary sector and review how the services are commissioned and procured through an ongoing review and assessment of models of intervention and evaluation of impact.

SP2-9- The timeframe for this needs to be changed is too short.

SP2-10-Finding needs to be fully communicated with all services as well as the implementation of changes and when they will be made.

SP2-12 Enhance advocacy services and peer mentors in treatment and recovery services.

We support this action and believe it should include an intention to include this in the revised service models that will be commissioned for community-based intervention services for young people and adults.

SP2-13 Realign PHA and other contracts for substance use and mental health support, to ensure services are provided to those in, and on the periphery of, the justice system.

We agree with this action however this needs to be considered in conjunction with SP2-15 in order that an alignment of the various services takes place to deliver more integrated model of support across the system.

SP2-15 Review substance misuse services for people who come into contact with Probation Board of Northern Ireland.

The lead organisations for this should include the Department of Justice. Budget restraints passed on to PBNI have already resulted in substantially reduced support for people with substance use problems and unless the funding from DOJ is addressed this is going to continue to be a barrier to addressing this action.

SP2-13 and SP2-15 should be short term actions as the risks and harms associated with weaknesses in the support systems across the justice system and the need to improve this have been highlighted as a priority in the commissioning framework, so the actions should be prioritised also.

SP2-17 Clearer guidelines are required around chlordiazepoxide detoxes in the community. Training especially around these issues is needed for Statutory and Community and Voluntary Sectors. G.P Federations need to be included in this conversation also. Development of stimulant detox in the community will need to be reviewed, at present very little if anything available.

Trauma Informed System

The most straightforward aspect of implementing a trauma informed approach is workforce development. Where the real challenge will lie is in the whole scale system change required if the approach is to take hold. The current system could be seen as overly rigid and while there may be recognition of the impact of trauma on an individual basis the client will still be penalised for perceived ‘lack of motivation’ for example.

The use of deficit-based assessments is another element that will require change – with a greater focus on a strength-based approach.

Trauma informed practice can only happen in the context of trauma informed and trauma responsive environments, policies, systems and organisations”. However, it is not enough to implement change to ensure a trauma informed approach across

substance use services only, this must be a system wide approach to include mental health, primary care, criminal justice etc.

Engagement at the highest levels of the organisation is critical for trauma-informed approaches to be successfully embedded.

SP3. This is an important, transformational issue but the actions are short term and within existing resources – greater focus will be required to achieve real change. Given the evidence relating to the role of trauma in substance use and the potential impact of adopting a trauma formed system approach there should be a commitment to a Trauma Informed approach as an underpinning principle for this action plan; and support for this approach should be secured across all departments, services and strategic work streams connected to substance use.

To truly embed a trauma informed system a more comprehensive investment is likely to be required. Current service models (usually 6 sessions) do not allow for the adoption of a trauma informed approach as this requires more time to ensure a safe and effective intervention.

SP3.4. Commission research to explore the trauma experienced by asylum seekers, refugees and other at-risk groups and make recommendations to adapt services" – other at-risk groups include those affected by domestic abusive relationships.

A Trauma informed system is very much needed as this can help with relapse prevention and aid long-term Recovery. Care Pathways need to be focussed and accessible. Not one cap fits all! They need to be well established and improve transition pathways as there is a persistent reality of poor service user experience.

Implementing a trauma-informed approach across all systems is an ongoing process, not a one-off event and must be managed as such.

Family Support

We strongly agree with the inclusion of family support as a strategic priority in this plan and therefore welcome that the voices of families and carers are not only heard but listened to as part of risk assessment and subsequent care planning. Families are key to Recovery; their own recovery and well-being is often overlooked. They also need to be educated around Addiction and Trauma.

However, we would like to stress that families should not be limited to what services are available due to a "postcode lottery" as such considerations should be made for more rural/ non centralised regions.

SP4-1. Develop/ facilitate a network of family peer support groups that will provide support for families and carers not only as advocates for those using substances but also as individuals who have been impacted and traumatised by their loved one's substance use, often at the cost of their own health" – It can be difficult to engage families in this support due to stigma and also because their primary focus is on how to support the person using substances rather than their own wellbeing. For this reason, consideration needs to be given as to how to attract families into these services and ensure they meet their needs/what they want to get out of the support.

SP4-1 Develop/ facilitate a network of family peer support groups that will provide support for families and carers not only as advocates for those using substances but also as individuals who have been impacted and traumatised by their loved one's substance use, often at the cost of their own health.

We support this action and the need for family support groups. There should also be provision for individual support. Interventions such as the 5 Step-Method have been developed and evidenced as supports for adults and such models should be embedded within future service design and the capacity of the workforce increased to delivery such interventions.

Family support should also extend beyond adult family members and carers, to include young family members. Steps to Cope has been developed by ASCERT, AFINet and SEHSCT as an adaptation of the 5 Step-Method and evidenced to support young people, strengthening their resilience to the impact of substance use and mental health in their family.

On Page 45 it says, we will enhance existing family systemic therapy provision with increased funding to the community, voluntary and statutory sectors. This evidence-based approach supports families in group settings to help family members better understand each other and the impact of substance use across the family unit. Investment in this approach aims to change negative behaviours, resolve existing conflicts, and empower families to create their own solutions.

We support this reference to systemic therapy as it is a highly effective model for therapeutic family support, however it is the model where there is least availability or capacity in services.

SP4-4. Commission a range of evidence based therapeutic interventions for families with lived and living experience of substance use". This is too broad, and it is a long-term action. The commissioning framework should include an action to specifically commission systemic family therapy provision in the short/medium term. Whole family approach is required.

Commission a range of evidence based therapeutic interventions for families with lived and living experience of substance use. However, this is too broad, and it is a long-term action. The commissioning framework should include an action to specifically commission systemic family therapy provision.

Stigma

We strongly agree with the inclusion of Stigma in the plan. Reducing the stigma is key, as, it is harmful. Many people do not present for support because of the stigma and shame.

However, it is important to note that whilst it has been recognised that stigma involves language, there is not enough emphasis on the Stigma generated by support models. Recovery/abstinence based/ Minnesota Models that focus of negative language which can be construed as Stigma.

SP5. There should be a commitment to reducing stigma as an underpinning principle for this action plan; and actions to support this approach should be embedded across all departments, services and strategic work streams connected to substance use.

Additional resources and longer-term funding will be required to effectively reduce stigma. Core training on stigma should be included for the wider workforce.

Workforce Development

The document says it will build on a range of training packages funded by the PHA through the Workforce Development Services and provide a pathway for alcohol and drug workers from all sectors to engage in substance use training in line with national standards.

This should not be restricted to 'drug and alcohol workers' as the development of knowledge and skills in working with people impacted by alcohol or substance use is also important to workers where they encounter substance use but it is not their primary role.

SP6. The interpretation of workforce should go beyond the HSC workforce, as there are many interfaces with alcohol and substance use across other sectors such as justice, education, community.

There is no action in the framework to commission training other than SP6-2 in relation to naloxone. Given that there are existing commissioned workforce development programmes the framework should specify if it intends to recommission of the Drug and Alcohol Workforce Development programme.

Workforce development would benefit from having a more targeted approach for settings – such as working with homeless substance users rather than a generic approach to raising awareness about the effects particular substances have. Employing people with lived experience should also be expanded.

Core training should include trauma informed practice and stigma reduction.

It is unclear if the current workforce development training programme will be recommissioned as it is not included in the commissioning actions.

Look to introduce training for trainers so organisations can tailor modules to their specific environment. Include service users in this so their experience can be maximised.

Digital Innovation

We strongly support Digital Innovation as a strategic priority plan. However, there needs to be recognition that this also include resources for the workforce both Statutory and Community and Voluntary sectors as well as for those affected by substance use both directly and indirectly.

Rurality and digital poverty must be strongly considered and the PHA/SSPG needs to work with other intergovernmental departments to make internet access available for all in Northern Irish Society.

Whilst NIADA agrees with the commissioning actions of the strategic priority 7- Digital innovation, it is felt that content needs to be reflective of modern thinking and there should be an avoidance of trying to “scare people sober”. Effective education has much more potential to reduce harms that eliciting fear.

SP7. Consistent use of the same digital resources will not only be more cost effective, but it will also lead to better experience for people using services as there will be more consistency.

Local services should be consulted on what would work best is most needed in their area as there may be differences across localities and population groups. There is potential for developing and trialling innovations though local services to meet needs.

Data and Research

We strongly agree that Research is vital to this work as it shows the need for an integrated approach and ensures better access to support when needed. It also shows the lack of services that are needed to carry out this work. This needs to be ongoing.

A significant area for development is effectively capturing the experience of the service user in relation to evaluating the impact of a service. Qualitative methods to elicit this information should be examined – service user feedback on whether they achieved their desired outcomes from the services they engaged with. We feel that collecting this information goes to the heart of the desire to achieve Quality Improvement.

This should be framed positively and realistically reflect the significance of incremental change as part of a journey that may involve numerous relapses. This strength-based approach would be in preference to those that start by focusing on the problems or deficits.

SP8-1 is young people only, but prevention and early intervention actions should be across the lifespan. This action should include researching what is effective prevention for the adult population.

This seems to be more service led which is great in theory. This ensures that the system focusses on people and their needs, rather than expecting people to conform to a rigid outdated system that is underdeveloped and underfunded.

Outcomes need to be clear, with an evidence-based framework that allows evidence to be the foundation for decision making.

We must have the right data to measure outcomes, which is comparable across trusts to measure performance and to determine what works.

We particularly like the action related to ‘Scope the viability of developing a practitioner - researcher training programme encouraging the organic development of practitioner researchers across each tier of substance use services. We would encourage this approach being expanded to include a service user research training programme also.

Time frames are difficult to manage and will prove challenging. Flexibility may be needed to reduce any stress on the services. The care plan needs to be continuous in terms of monitoring and evaluation.