Northern Ireland Alcohol and Drug Alliance: Impacts of COVID-19 on People Who Use Services and Providers

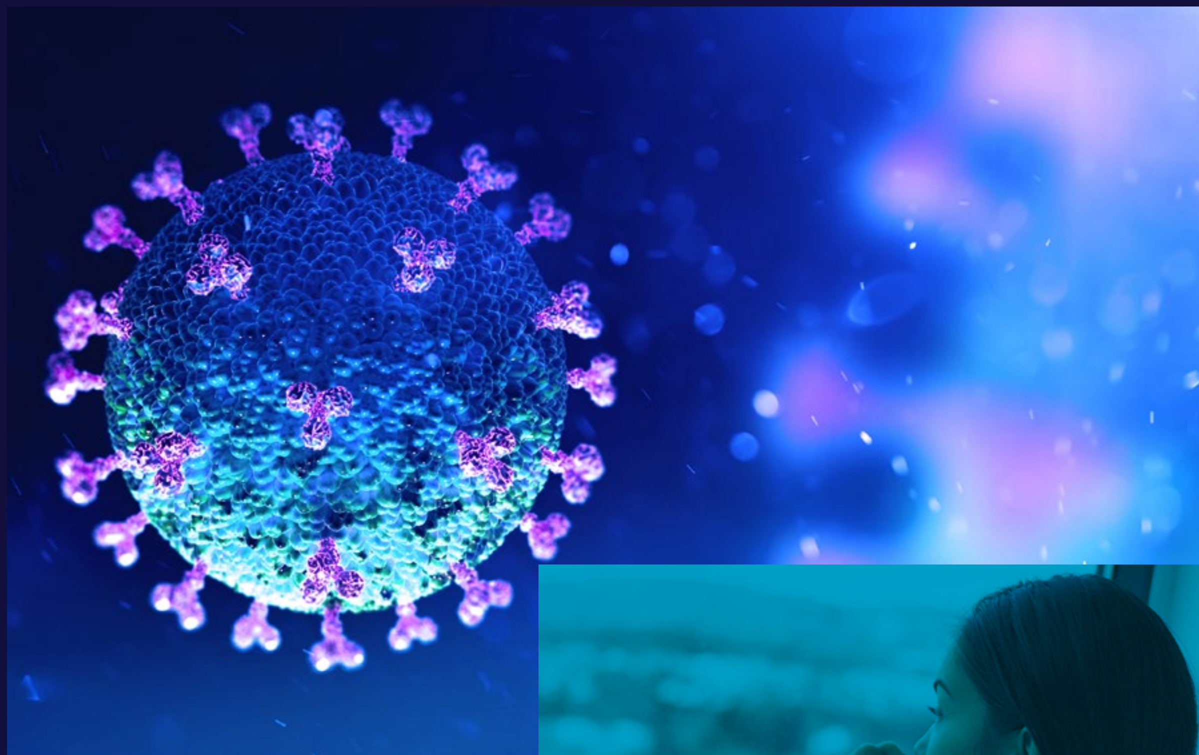

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Table of Contents

1. Introduction 4

2. Study Design 9

3. Sample Characteristics 12
3.1 Service Provider Survey 12
3.2 Service Provider Focus Group and Interview Demographics 13
3.3 Family Member Focus Group and Interview 13
3.4 Client Survey Demographics 13
3.5 Client Interview Demographics 15

4. Health and Social Impacts of COVID-19 16
4.1 Impacts of COVID-19 on Population Groups 16
4.2 Mental Health 17
4.3 Physical Health 24
4.4 Family Relationships 28
4.5 Financial Situation 29
4.6 Other Adverse Outcomes Related to COVID-19 29

5. Impacts of COVID-19 on Drug Markets, Use and Related Behaviours 32
5.1 Drug Markets 32
5.2 Main and Secondary Drug Use 37
5.3 Drug Use Patterns 40

6. Impacts of COVID-19 on Service Delivery 63
6.1 Impacts on Service Delivery 63
6.2 Methods Employed Due to Infection Control Measures 64
6.3 Challenges to Service Delivery 66
6.4 Positive Impacts on Service Delivery 79
6.5 Going Forward 85

7. Conclusions and Recommendations 95
7.1 Health and Social Impacts 95
7.2 Drug Markets, Use and Related Behaviours 97
7.3 Service Delivery 100

References 102

1. Introduction

1.1 Background

The COVID-19 pandemic and subsequent public health responses substantially affected the everyday lives of people on a global basis, including those in Northern Ireland. The government in Northern Ireland introduced a range of social distancing and infection control measures which constrained mobility and led to temporary closures of education, business and other leisure establishments (NIAO, 2021, 2020a). While such measures disrupted the lives of the general public in Northern Ireland, similar to other jurisdictions (May et al., 2022; British Academy, 2021), they disproportionately affected the most marginalised in society which includes people who use/d drugs. In particular, many of those with drug dependency rely heavily on health and social care services for help and support which were substantially affected by infection control measures (Higgins et al., 2020; Campbell et al., 2021).

Preliminary research in Northern Ireland found that compliance with infection control measures led some people who use/d drugs and their families to experience adverse health and social impacts (Higgins et al., 2020; ASCERT, 2020). Constrained mobility, business closures and reduced substance use services appeared to affect drug markets, drug use patterns and new risk-taking practices for some populations (Croxford et al., 2021; Campbell et al., 2021; Rintoul and Campbell, 2021; Higgins et al., 2020). Public health measures also resulted in substantial changes to the delivery of substance use treatment and support services (DOH, 2021a; Higgins et al., 2020). Programmes were either reconfigured to remote delivery or a compatible format, while other services were reduced or temporarily suspended.

However, as existing research focuses on the early stages of the pandemic in Northern Ireland (Croxford et al., 2021; Campbell et al., 2021; Rintoul and Campbell, 2021; Higgins et al., 2020; ASCERT 2020), there was a need to examine the ongoing impacts of the pandemic on people who use/d drugs particularly with regard to health and social issues, drug markets, patterns of use and related harms. More information was required on how services adapted to the changed environment and if changes worked or could be improved upon, issues largely absent from previous research. The current study investigated these issues from the perspective of people who use/d drugs, family member and service providers. Findings provide important policy and practice insight.

1.2 Northern Ireland Drug and Alcohol Alliance

The current study was funded by the Northern Ireland Drug and Alcohol Alliance (NIADA). NIADA (2022) facilitates co-operation among fifteen[1] voluntary and community sector organisations supporting people affected by substance use, and their families. Member organisations provide a wide, holistic range of services throughout each of the five Health and Social Care Trust (HSCT) areas in Northern Ireland to children, young people, adults and their families affected by substance use. While the size and focus of member organisations vary, their programmes cover all aspects of substance use from early intervention and harm reduction through to recovery and aftercare services.

1.3 Aim and Objectives

The research aimed to examine impacts of the COVID-19 pandemic on NIADA clients' substance use, related behaviours and delivery of services. The research objectives were to:

- Explore the impacts of COVID-19 on clients' physical and mental health needs;
- Establish the impacts of COVID-19 on patterns of alcohol and/or other drug use behaviours;
- Examine sources of support for people who use services;
- Evaluate the impacts (challenges and opportunities) of remote working and/or blended approaches upon people who use services and providers;
- Provide recommendations for future policy and service delivery.

[1] There were 13 organisations in NIADA during fieldwork for this study.

1.4 Policy Context

'Preventing Harm, Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use 2021-31' is the new drug strategy for Northern Ireland released during fieldwork for this study (DOH, 2021a). The policy promotes an integrated public health-led approach to deal with substance use and recognises the necessity of working collaboratively with a range of departments to mitigate the multi-faceted reasons for problematic substance use and reduce drug-related harms. It acknowledges the urgent need for alignment of substance use and mental services in Northern Ireland. Given the recent launch of this policy, understanding the COVID-19 impacts on drug use trends, related behaviours and service delivery is vital for strategic actions and implementation.

1.5 Guidelines and Support Issued to Services in Northern Ireland

The Department of Health (2020) issued guidance to help substance use services address the challenges of complying with social distancing and infection control measures. The guidelines sought to ensure services were safe for staff and people using services. Guidelines were informed by various professional bodies throughout the United Kingdom (UK) including Public Health England and the Scottish Drugs Forum. They contained advice on how to ensure most services remained operational during the pandemic. Specific areas covered included advice for: children and family services; mental health support; accessing opioid substitution treatment (OST); needle and syringe exchange services (NSES); drug detoxification; harm reduction; non-medical support; and advice for engaging with people not in substance use treatment.

In addition, a COVID-19 Addictions Subgroup was established to ensure regular communication between the Department of Health (DOH), Health and Social Care Board (HSCB), Public Health Agency (PHA) and the five local Health and Social Care Trusts (HSCT) (DOH, 2021a). The subgroup provided information on regional activities needed to respond to COVID-19 outbreaks and how these were to be applied to substance use service providers across Northern Ireland. The impacts of the pandemic on service providers were managed within existing financial and workforce resources with adaptions made if need arose. The PHA also continued to highlight specific drug-related harms and information on local sources of help and support for the general public and those with drug use dependency.

1.6 Adverse Health and Social Impacts of COVID-19 on People who Use Drugs

Emerging research on the health and social impacts of COVID-19 suggests that people who use/d drugs have been adversely affected by a wide range of issues (May et al., 2022; EMCDDA, 2021a). People dependent on drugs, those who inject and/or part of the homeless community appear to be particularly susceptible to the most adverse impacts (May et al., 2022; British Academy, 2021; Campbell et al., 2021). Their previously marginalised and stigmatised status and experience of social and health inequalities was heightened by the impacts of social distancing and infection control measures (Bennet et al., 2021; Kreteson et al., 2021).

A major adverse health impact of the pandemic has been deteriorating mental health (WHO, 2022). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2021) highlighted that COVID-19 impacts on the mental health of the general population have been exacerbated for people who use drugs especially those with dependency and women who use drugs. Deteriorating mental health was evidenced through increased levels of anxiety, depression, stress, self-harm, suicide attempts and suicides due to COVID-related fears, social isolation, unemployment, financial difficulties and relationship breakdowns combined with reduced mental health services (EMCDDA, 2021a).

Similar deteriorating mental health among people who use/d drugs has been discerned in Northern Ireland (Higgins et al., 2020; HSC, 2020). The first mixed methods NIADA study during the early stages of the pandemic found that while clients reported good physical health, over two thirds (65%) reported poor/very poor mental health (Higgins et al., 2020). Providers reported intensified and more complex needs among clients with pre-existing poor mental and/or physical health. Poor mental health was evident through rising levels of anxiety and depression due to feelings of isolation and loneliness, fear of contracting COVID-19 and worry about family members or friends. Increased numbers of family members approaching services for help also expressed these sentiments. A rapid review of the mental health impact of COVID-19 in Northern Ireland also suggested that isolation, loneliness, stigma, domestic violence, economic recessions, and unemployment could increase the propensity for alcohol and other substance use dependency and mental health problems (HSC, 2020).

Another important health issue is the impact of the pandemic on alcohol and other drug-related deaths. The full impact of the pandemic on overdose and drug-related deaths is still being determined with the EMCDDA (2021a) discerning mixed results dependent on the country. Official statistics in Northern Ireland reported record levels of alcohol and other drug-related deaths during 2020 with the highest levels recorded in areas experiencing high levels of socio-economic deprivation (NISRA, 2022a,b; Hughes et al. 2021, 2020). The most recent drug-related deaths figures for 2021 report the second highest number on record, six less than the 2020 peak of 218 people (NISRA, 2022c). While elevated levels may be related to the pandemic, the number of deaths consistently rising until 2021 indicate the role of other factors, such as poverty, socio-economic inequalities, increased polydrug use and/or lack of engagement or disengagement with treatment services (DOH, 2021a; Hughes et al. 2021, 2020; PHE, 2021). Higgins et al. (2020) and Campbell et al. (2021) discerned that during the early stages of the pandemic there were lower numbers of reported overdoses and drug-related deaths due to concerns about hospital admission and potential exposure to COVID-19 infection. However, rates increased following the first lockdown period and linked to increased use of street-sourced benzodiazepines and alcohol (Campbell et al., 2021).

Concerns have been expressed about increased social harm related to robbery and violence among people using drugs with strained financial resources resulting from pandemic restrictions creating more tension and conflict (May et al., 2022; Bennett et al., 2021; EMCDDA, 2021a). During the early stages of the pandemic in Northern Ireland, Higgins et al. (2020) and Campbell et al. (2021) observed that lockdowns, social distancing and temporary closures of businesses affected income-generating activities among people whose main source of income for their drug use was begging in city centres. Consequently, financial pressures created interpersonal tensions and conflict with peers (Campbell et al., 2021).

1.7 Drug Markets

While research into the impacts of COVID-19 on drug markets is ongoing, they appear to have remained relatively resilient (EMCDDA, 2022). The EMCDDA (2021a) noted some disruptions to street-based retail markets during the initial stages of the pandemic. However, markets adapted to the changed environment. A major adaption was 'increased use of encrypted messaging services, social media applications, online sources and mail and home delivery services' (EMCDDA, 2021a: 4). The Police Service in Northern Ireland also suggested these changes were becoming more common during 2020 (McCracken, 2020).

Existing research also identified shortages of particular drugs in local drug markets during the first lockdown period (Higgins et al., 2020; Campbell et al., 2021). Higgins et al. (2020) reported difficulties accessing cannabis combined with elevated cost and reduced quality. Campbell et al.'s (2021) qualitative research with people who inject drugs in the homeless community in Belfast identified a temporary decrease in heroin use due to inaccessibility and more restricted sources as noted earlier. Cocaine, synthetic cannabinoids, street manufactured benzodiazepines and other prescription medication markets appeared unaffected.

1.8 Patterns of Drug Use

Regarding patterns of drug use during the pandemic, the EMCDDA (2021a) reported reduced drug use during the first lockdown but observed that use returned to pre-pandemic levels during subsequent lockdowns. There was also increased use of certain drugs (e.g., alcohol, cocaine and benzodiazepines) dependent on the country.

In Northern Ireland there is some evidence of reduced use among some populations during the early stages of the pandemic (Campbell et al., 2021; Higgins et al., 2020) but, here too, use returned to previous patterns once COVID-19 infection rates decreased and/or supply and/or access issues were resolved. Increased use of alcohol, cocaine, prescription medications and street-sourced benzodiazepines and elevated levels of polydrug use was observed among some client groups by providers (Higgins et al., 2020). During periods of inaccessibility and/or concerns about cost and/or purity and/or financial difficulty, some people using heroin or cannabis, substituted with other drugs. These drugs included street-sourced benzodiazepines, cocaine and synthetic cannabinoids.

1.9 Injecting-related Harms

The EMCDDA (2021a) contends it is too early to ascertain if the pandemic affected rates of hepatitis C (HCV) and human immunodeficiency virus (HIV) among people who inject drugs. However, there was disruption to accessing relevant services which may increase transmission rates.[2] Croxford et al. (2021) used the cross-sectional Unlinked Anonymous Monitoring Data on people who inject drugs in England and Northern Ireland to examine the pandemic impacts on injecting behaviours (PHE, 2021). Findings suggested increased frequency of injecting, increased levels of cocaine injection, slight increase in direct sharing of injecting paraphernalia and increased alcohol use (Croxford et al., 2021; PHE, 2021). Results suggested changed patterns of injecting drug use and increased injecting-related harms.

Other research in Northern Ireland suggested further injecting-related harm due to elevated levels of transitions to injecting and more harmful groin injecting behaviours (Rintoul and Campbell, 2021; Campbell et al., 2021; Higgins et al. 2021; PHE, 2021). For example, Campbell et al. (2021) identified a younger cohort of inexperienced people in the homeless community injecting drugs in Belfast. Their limited knowledge of injecting resulted in infections, abscesses and hitting nerves. Combined, this evidence suggested increased injecting-related harms in some parts of Northern Ireland during the pandemic.

1.10 Substance Use and Related Services in Northern Ireland

Following the first lockdown and rapid transition to remote service delivery via phone and video communication, face-to-face services resumed within many drug services, subject to strict prevention protocols (EMCDDA, 2021a). The EMCDDA (2021a) reported that overall capacity in services was reduced and there were longer waiting times for face-to-face consultations. However, some professionals reported that the pandemic forced providers to re-evaluate working procedures and, for some services, this resulted in increased efficiency and innovation in service provision.

[2] See Section 1.10.

Phone or video communication became an essential tool for ensuring health and social care services remained operational during lockdown periods (EMCDDA, 2021a). Benefits included reaching new clients in remote areas where physical services were limited and it was an efficient way of connecting to other services improving client referrals. However, some client groups experienced difficulties using the technology, particularly older people, those in contact with the criminal justice system and/or with severe mental health issues and complex comorbidities. Inequalities in digital literacy and internet connections were discerned between urban and rural locations for clients and providers.

Problems were also highlighted with using technology for group or family therapy and carrying out initial assessments for new referrals (EMCDDA, 2021a). Some services also raised issues about client privacy and confidentiality using phone and video. In addition, lack of face-to-face contact exacerbated social isolation for some client groups. Research in Northern Ireland during the first lockdown also found that the rapid reconfiguration to phone and video-links was challenging to substance use services in the voluntary and community sector (Higgins et al., 2020). Providers were concerned about how clients would respond given that there was no precedent for this service delivery method. They tried to mitigate potential negative impacts through ensuring regular phone 'check ins' with clients (Higgins et al., 2020; ASCERT, 2020).

During the initial stages of the pandemic, the HSCB directed a stand-down of pharmacy supervision of consumption arrangements for OST (DOH, 2020). The three specialist inpatient detox and two specialist inpatient rehabilitation units were temporarily closed to admissions due to difficulties implementing social distancing. For other substance use services in the statutory, voluntary and community sector, major transitions were made to a mixture of face-to-face/ phone support with interventions predominantly continuing via phone and video-links. Particular attention was given to measures designed to support people with acute drug dependency ensuring relevant services remained operational and accessible across all HSCT areas. The DOH (2021a) reported that most services remained operational during the pandemic.

Higgins et al. (2020) discerned increased pressure on substance use services in the voluntary and community sector during the pandemic due to difficulties accessing primary healthcare, mental health and other services. This was at a time of heightened demand for services with increased presentations of family members, increased relapse rates and more people presenting with complex needs due to changing drug use patterns. However, despite these challenges, the voluntary and community sector fulfilled an important and vital source of support for mental health and substance use services during the pandemic.

In addition, harm reduction services, such as NSES, provision of naloxone and safer drug use advice, continued to be available with low threshold statutory and voluntary outreach organisations delivering the services face-to-face during the pandemic (Campbell et al., 2021). However, barriers to accessing these services and related treatment services were identified (Croxford et al., 2021; PHE, 2021). Croxford et al. (2021) found that people who injected drugs had more difficulty accessing substance use treatment services, bloodborne viruses (BBV) testing, sterile injecting equipment, OST, naloxone, other medicine and healthcare during the pandemic. These service disruptions may have increased injecting-related harms.

1.11 Conclusion

The current study builds on preliminary NIADA research conducted in Northern Ireland between mid-May and the end of June 2020 (Higgins et al., 2020). It provides an updated and deeper understanding of the ongoing health and social impacts of the pandemic on people who use/d drugs, drug markets, patterns of use and service delivery from the perspective of NIADA clients, family members and service providers. In doing so, recommendations for policy and practice are provided.

2. Study Design

A sequential mixed methods approach composed of journal entries, cross-sectional surveys, focus groups and semi-structured interviews was used. Combining these methods has provided rich and credible data evidencing NIADA clients, family members and providers experiences and needs (Seale, 2017). The study consisted of two phases.

2.1 Phase 1

2.1.1 Journal Entries

Similar to Higgins et al. (2020) research, NIADA organisations were asked to maintain weekly journals for a five week period (31st May to 2nd July 2021). Three organisations participated resulting in 56 journal entries. Observations on how the COVID-19 pandemic was affecting clients' substance use, needs and service delivery were recorded. Journal entries were brief and concise with choice offered to record reflections in the most suitable manner. Entries were submitted weekly via email to the research team. This data provided important insight into current trends in clients' substance use, needs and service delivery reinforcing survey, focus groups and interview findings.

2.1.2 Service Provider Survey

A short online survey was emailed to all NIADA organisational leads[3] to ascertain views on how COVID-19 affected people using their services and programme delivery. Parts of the questionnaire were adapted with consent from Burton et al.'s (2021) rapid evidence assessment of COVID-19 impacts on substance use services in Ireland. Ten NIADA organisations completed the survey during May to June 2021. Topics included: COVID-19 impacts on service clients' substance use; physical and mental health needs; and service delivery. This data provided important baseline information and informed focus group topics, interviews and Phase 2 of the research.

2.1.3 Service Provider Focus Groups and Semi-Structured Interviews

To provide depth to survey findings, NIADA organisational leads were invited to participate in focus groups or semi-structured individual interviews if they could not attend a focus group due to work schedules. Ten representatives from nine NIADA organisations participated in either a focus group (n=8) or interview (n=2) in June 2021. Given COVID-19 restrictions, the three focus groups and two semi structured interviews were conducted on Zoom. Focus groups lasted between 60 and 75 minutes and interviews between 45 to 50 minutes. Topics included: perceptions about COVID-19 impacts upon clients' substance use and needs; opportunities and challenges with regard to service provision; and recommendations for future service delivery. This qualitative data provided rich information triangulating findings and informed topic selection for Phase 2.

2.1.4 Family Members Focus Group and Semi-Structured Interview

NIADA organisations providing services to family members of people who use substances throughout the different Health and Social Care Trust (HSCT) areas in Northern Ireland advertised the study. Contact details of interested family members were provided to the research team or participants contacted the research team directly via email. Three family members participated in a Zoom focus group (n=2) or a semi-structured interview (n=1) during June to November 2021. Inclusion criteria was: aged 18 years and above; currently have or had a family member using substances during COVID-19 lockdown periods; and currently engaged with a NIADA organisation offering family services.

The focus group lasted for 75 minutes and the interview 25 minutes. Topics included: perceptions and experiences of COVID-19 impacts upon family members' drug use; sources of support for family members and their relatives; service delivery in the context of COVID-19; and recommendations for future service delivery. Despite the small number of participants, they provided deep and insightful information on important issues which complemented and expanded upon other data sources.

[3] There were thirteen NIADA organisations at the time of data collection for the study.

2.2 Phase 2

2.2.1 Client Survey

An online (n=89), telephone (n=5) and face-to-face survey (n=4) was conducted with 98 NIADA clients aged 16 years and older between 1st July to 31st November 2021. Parts of the survey were adapted with consent from the questionnaire created by Higgins et al., (2020) with new questions added on attitudes towards remote and/or blended approaches to services and other drug use behaviours. Inclusion criteria was: aged 16 years and above; currently engaged with a service provided by a NIADA organisation; currently uses or used substances during the COVID-19 lockdown periods in Northern Ireland; and/or currently in long-term substance use recovery. Purposive sampling was employed. NIADA organisations sent an advertising flyer to clients, support/key workers advertised the research and assisted clients who did not have internet access. Sampling was monitored to ensure a diverse range of ages, genders, substance use behaviours and engagement with differing services.

2.2.2 Client Semi-Structured Interviews

To add depth to survey data, qualitative semi-structured interviews were conducted with people currently using NIADA services who had completed the survey (n=10) during June to November 2021. Clients indicated interest in interview participation on the questionnaire and provided either a phone number or email address. The research team contacted potential participants and ten were subsequently interviewed. Interviews lasted between 25 and 55 minutes. Participant inclusion criteria was: aged 16 years and above; participated in the client survey; currently engaged with a service provided by a NIADA organisation; currently uses or used substances during the COVID-19 lockdown periods in Northern Ireland; and currently in long-term substance use recovery. Interviews were conducted using Zoom (n=8) and phone (n=2). Topics included: COVID-19 impacts upon patterns of drug use; physical and mental health needs; sources of support; experiences of service delivery during COVID-19; and recommendations for future service delivery.

As five NIADA organisations provide extensive substance use services to young people, the study aimed to include representation of 14 and 15 year old clients. For ethical reasons they had not been invited to participate in the survey. Relevant NIADA organisations sent an advertising flyer to this client group and support/key workers also advertised the study. Contact details of interested participants were given to the research team who then followed up with participants and their parents/guardians. Inclusion criteria was: aged 14 or 15 years old; currently engaged with a service provided by a NIADA organisation; and currently uses or used alcohol and/or other drugs during the COVID-19 lockdown periods in Northern Ireland.

One interview lasting 15 minutes was conducted using Zoom during July 2021. Topics covered included: impacts upon patterns of drug use; physical and mental health needs; sources of support; experiences of service delivery during COVID-19; and, recommendations for future service delivery.

2.3 Data Analysis and Interpretation

Qualitative data was thematically analysed enabling identification of similarities and differences in the experiences and viewpoints of participants (Braun and Clarke, 2021). A coding scheme was devised and data coded into emergent themes. Survey data was inputted into SPSS to produce graphs and frequency tables. Descriptive and inferential statistical testing was applied to quantitative client data using SPSS version 27. Independent samples t-tests, ANOVA, chi square, Cramer's v and phi were used to determine statistical significance where appropriate in the client survey. However, significant results should be treated with caution given the small number of participants (n=98).

Integrated results based on qualitative and quantitative data have been presented in the findings sections of this report. Survey results are presented in graphs as frequencies due to the small numbers of participants and percentages are also used when appropriate. Findings have been analysed by subgroups; service type; HSCT area; gender, age, work status, home location; and drug type where appropriate. Thematic qualitative results are presented after relevant survey results for depth of understanding.

2.4 Ethical Considerations

The study was ethically approved by Ulster University School of Applied Social and Policy Sciences Ethics Filter Committee (Phase 1) and the University Research Ethics Committee (Phase 2). The study adhered to ethical principles and guidance provided by the British Society for Criminology (BCS) (2015), the United Kingdom (UK) Policy Framework for Health and Social Research (HEA, 2021) and Ethical Research Involving Children (2021).

Informed consent was obtained from each participant (BCS, 2015; ERIC, 2021; HEA, 2021). Research information was explained verbally and in written format before participation. Voluntary participation was emphasised. Careful attention was given to explaining the project in an age-appropriate manner with any outstanding questions answered by the research team. All focus group and interview participants were provided with information sheets and submitted a signed e-consent or e-assent form via email at least 48 hours before the focus group or interview. Parental/guardian consent was obtained for the participant aged under 16 years old (BCS, 2015; ERIC, 2021).

Maintaining participant anonymity and confidentiality was central. All interviews and focus groups were audio recorded with consent and transcribed within 48 hours. Audio recordings were deleted after transcription. Participating NIADA organisations provided consent for their organisational name to be used with individual representative names withheld. Random identification numbers have been used for all people using NIADA services. Research data was password secured and stored on an Ulster University computer with back-ups on the secure server OneDrive and accessible by the researchers in line with GDPR and the Data Protection Act 2018.

2.5 Limitations and Strengths

While every effort was made in designing, conducting and analysing this research, there are some methodological limitations. Given the small sample size for surveys (NIADA clients, n=98; NIADA providers, n=10), it would not be possible to generalise from this study to all people engaged with NIADA organisations, nor the experiences of all NIADA organisations and other providers in the voluntary and community sectors.

The sample may be biased towards those clients and NIADA organisations who were willing and able to participate in the survey, focus groups and interviews. All clients were also engaged with a NIADA organisation at some point during the COVID-19 pandemic. Therefore, the views and experiences expressed in this study may differ from those unwilling or unable to participate and those not engaged with services (Bauermeister et al., 2012; Fielding et al., 2017).

While some clients were engaged with statutory substance use services, these providers were also not directly included in this research. Thus, the experiences and views expressed in this report may not be shared by providers in the statutory sector.

However, a major strength of this study is the capturing of multiple perspectives on the impacts of pandemic from NIADA providers at senior level, people who use services and family members. This has produced detailed and insightful findings adding to understanding of the pandemic impacts on these important topics.

The mixed methods sequential design is a further strength of the study. This approach mitigated important methodological limitations and biases of single method research ensuring valid and credible findings (Carter et al., 2014; Creswell and Plano, 2018). Survey data provided general characteristics and understanding of the impacts of COVID-19 which was enhanced through more nuanced qualitative exploration of experiences and views providing depth of understanding. Triangulating data sources allowed for clarification and confirmation of key themes while mitigating potential biases and ensuring insight into the covered topics (Carter et al., 2014; Denzin 1989). This important insight will help to inform policy and practice going forward.

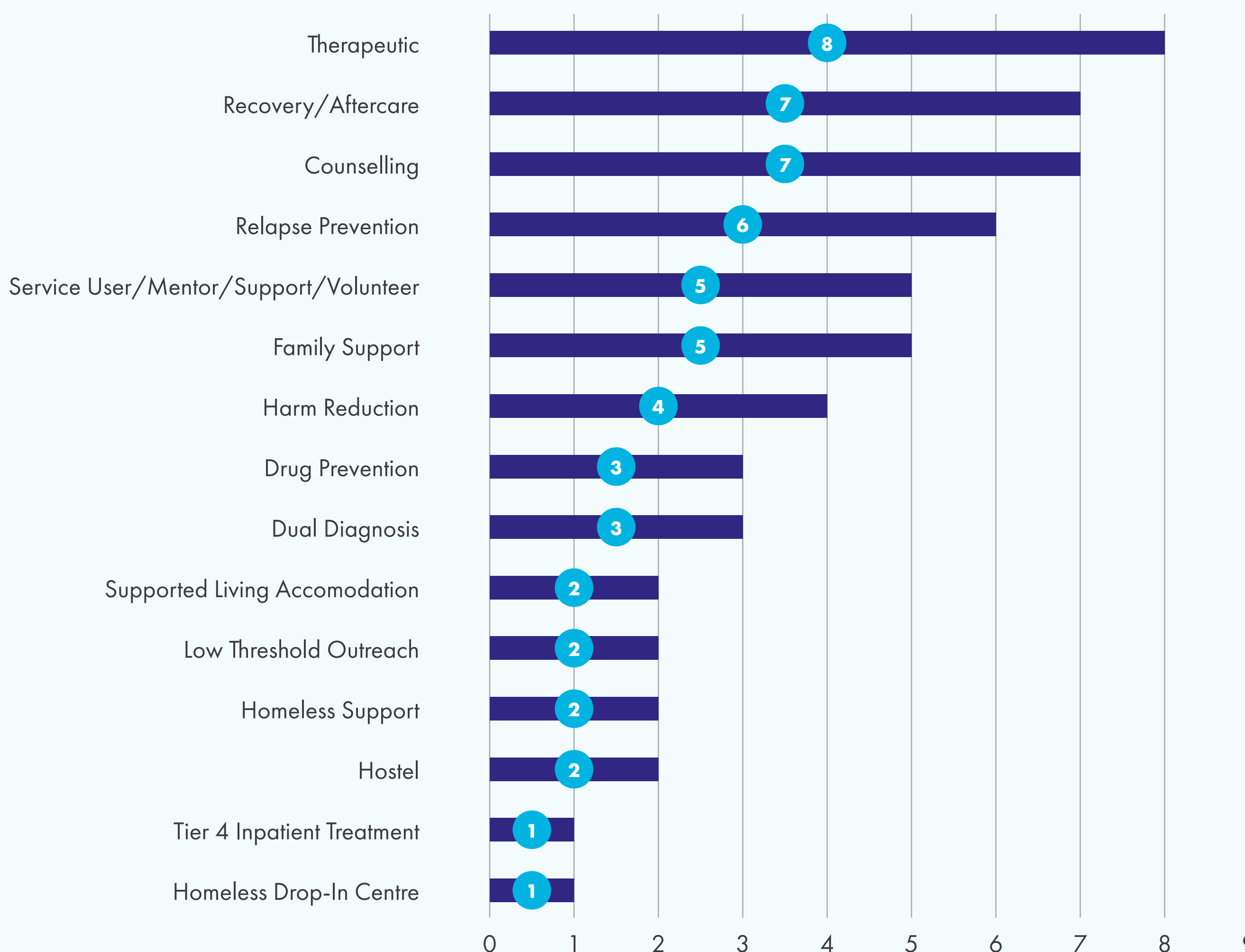
3. Sample Characteristics

This section summarises characteristics of the study participants.

3.1 Service Provider Survey

Ten NIADA organisations participated in the service provider survey. Figure 1 summarises the substance use and related services provided during the pandemic by NIADA organisations who took part in the survey, focus groups and interviews.

Figure 1: Service Type



Most organisations provided therapeutic services for people who use/d drugs (80%), followed by recovery/aftercare (70%), counselling (70%), relapse prevention (60%), peer services/representations (50%), family support (50%), and harm reduction services (40%).

Various other harm reduction, inpatient treatment and low threshold services were also provided. Figure 1 clearly demonstrates the wide, holistic range of services provided by NIADA organisations throughout the COVID-19 pandemic from early intervention to aftercare/recovery services.

Figure 2: Health and Social Care Trust Area

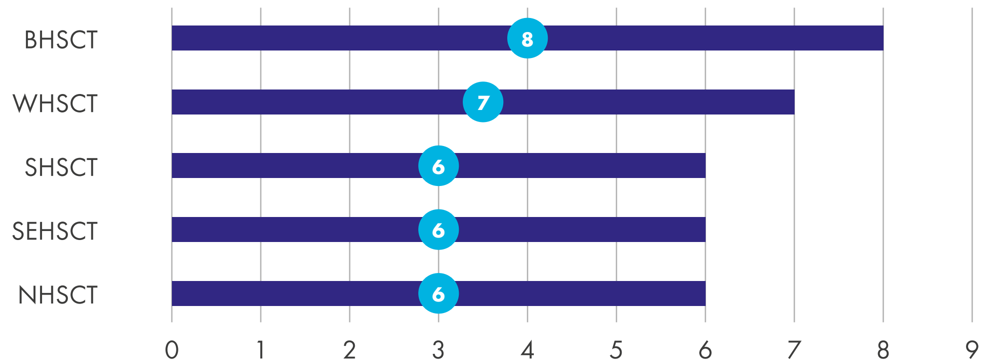


Figure 2 shows that organisations worked throughout all the HSCT areas in Northern Ireland during the pandemic.

A total of 80% worked in the Belfast HSCT (BHSCT), 70% in the Western HSCT (WHSCT) and 60% worked in the Southern HCT (SHCST), South Eastern HSCT (SEHSCT) and Northern HSCT (NHSCT) areas respectively.

3.2 Service Provider Focus Group and Interview Demographics

Ten representatives (m=5, f=5) from nine NIADA organisations participated in either a focus group or interview. All currently worked for a NIADA organisation, had experience delivering services throughout the pandemic, and worked in at least one of the HSCT areas.

3.3 Family Member Focus Group and Interview

Three family members participated in the study. Each participant was a woman, currently engaged with a NIADA family member service and had a family member who had used substances during the pandemic.

3.4 Client Survey Demographics

Figure 2: Client Gender

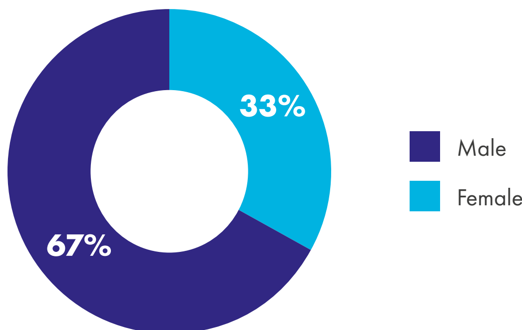
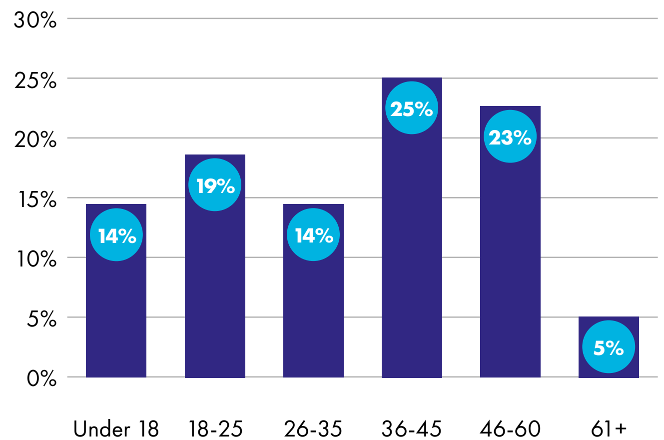


Figure 3: Client Age Groups



A total of 98 people who used NIADA services participated in the survey. Similar to Higgins et al. (2020), over two thirds were male (67%) which reflects published statistics on people presenting to services for problematic substance use in Northern Ireland (IAD, 2019).

Age ranged between 16 and 71 years and the average was 36 years. Participants aged under 18 years accounted for 14% of the total sample which is higher than the most recent official data on people presenting to treatment services for help with substance use in Northern Ireland (IAD, 2019). Similar to Higgins et al. (2020), the higher number is likely connected to the range of services provided by participating NIADA organisations and increased likelihood of this age group being engaged with services.

Figure 4: Client Home Location

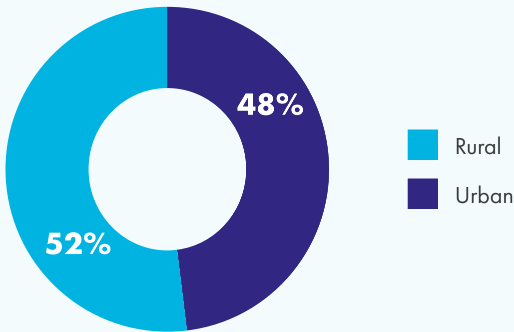
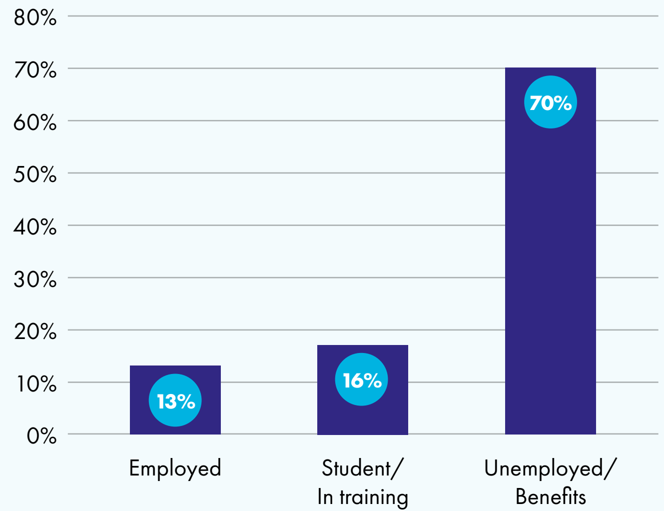


Figure 5: Client Work Status



Slightly more people lived in a rural area (52%) compared to an urban (48%) location in Northern Ireland.Most participants were unemployed and/or receiving social security payments (70%).

Figure 6: Clients' Used Drugs During Pandemic

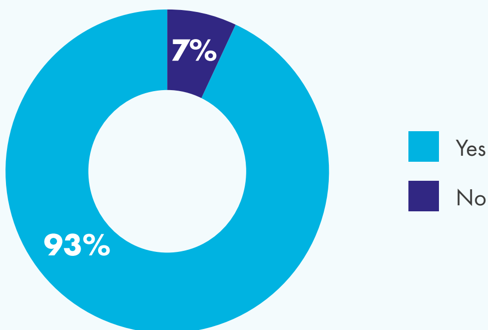
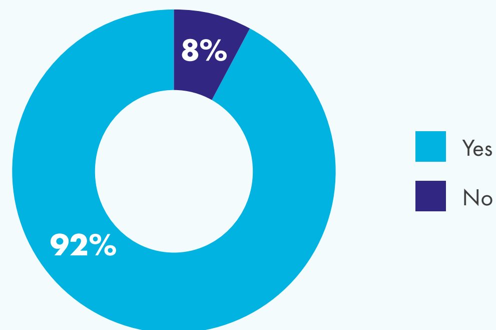


Figure 7: Clients' Current Drug Use



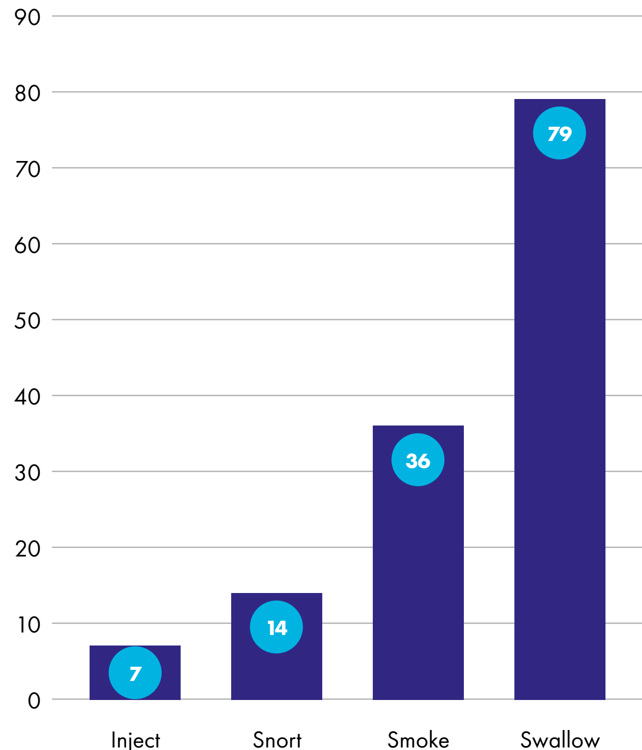
Drug use during the pandemic was self-reported by 93% of participants. Figure 7 shows that out of the 92 people who had used drugs during the pandemic, 92% reported currently using drugs.

Therefore, the sample was composed mostly of people who had used drugs at some point during the pandemic, with 7% in longer term recovery from substance use.

Table 1: Clients' Current Drug Use

Current Drug Use	N	%
Alcohol	70	82%
Cannabis	36	42%
Cocaine/Crack Cocaine	18	21%
Benzodiazepine	17	20%
Pregabalin	13	15%
Codeine*	11	13%
Heroin	10	12%
OST**	8	9%
Other Opioids***	6	7%
MDMA	4	5%
Amphetamine	4	5%
Ketamine	2	2%
Spice	2	2%

Figure 8: Clients' Current Route of Administration[4]



* E.g., Co-Codamol or Nurofen Plus; ** E.g., tramadol, morphine, dihydrocodeine; *** E.g., tramadol, morphine, dihydrocodeine.

Regarding types of current drug use, participants could select more than one option. Table 1 reports most clients were currently using alcohol (82%). The second most common drug was cannabis (42%), followed by cocaine/crack cocaine (21%), benzodiazepines (20%) and pregabalin (15%). It is important to denote that 47% of NIADA clients reported using one current drug, while 53% indicated use of two or more drugs[5]. While the numbers are small, this result suggests polydrug use is growing in Northern Ireland (DOH, 2021a; Higgins et al., 2020).

Participants could select multiple options for how they took their current drug/s. Most people swallowed their current drug (86%), followed by smoked (39%), snort (15%) and inject (8%).

3.5 Client Interview Demographics

Eleven semi-structured interviews (m=8, f=3) were conducted with people currently engaged with a NIADA service for support with substance use. Age ranged from 15 to 55 years with an average age of 44 years. Six participants were employed (f=3, m=3), four were receiving benefits (m=4) and one was in full-time education (m=1) at the time of interview. Most lived in a rural location (f=2, m=6) with three living in an urban location (f=1, m=2) in Northern Ireland. Participants had varied drug use backgrounds including alcohol (m=4, f=2), cannabis (m=6), heroin (m=5), OST (m=3), other opioids[6] (f=2, m=1), benzodiazepines (f=1, m=2), and crack cocaine (m=2). At the time of interview, six (f=1, m=5) were currently using substances, five (f=2, m=3) reported being abstinent and three (m=3) were receiving OST.

[4] The graph is based on the number of responses and not percentages.'
[5] The maximum number of main drugs reported was 11 current drugs (1%).
[6] Including morphine patches and codeine-based medications.

4. Health and Social Impacts of COVID-19

This section presents results on the health and social impacts of COVID-19 on NIADA clients from the perspective of service providers, clients and family members. The pandemic's impact on population groups, mental health, physical health, family relationships, financial situation and other adverse outcomes are discussed.

4.1 Impacts of COVID-19 on Population Groups

In the survey, NIADA providers were asked the extent to which the below population groups were affected by the COVID-19 pandemic. The 'don't know' responses indicate that prisoners, the Lesbian, Gay, Bisexual, Transgender, Queer, plus (LGBTQ+) community and sex workers are the most underrepresented client groups for participating services.

Figure 9: Impacts of COVID-19 on Client Population Groups

Figure 9 indicates that women were the most affected client group (100%), followed by men (100%), the homeless community (80%), older people aged 50 years plus (80%), younger people aged under 18 years (70%), ex-prisoners (50%), prisoners (30%), LGBTQ+ community (30%) and sex workers (30%). Two other client groups were identified in the provider survey; those with dual diagnosis and family members of people who use substances. Qualitative findings presented in subsequent sections provide depth to these results, identifying the positive and negative impacts of the pandemic on these population groups. Similar and differential impacts on clients were connected to drug use patterns, service engagement and delivery during the pandemic.

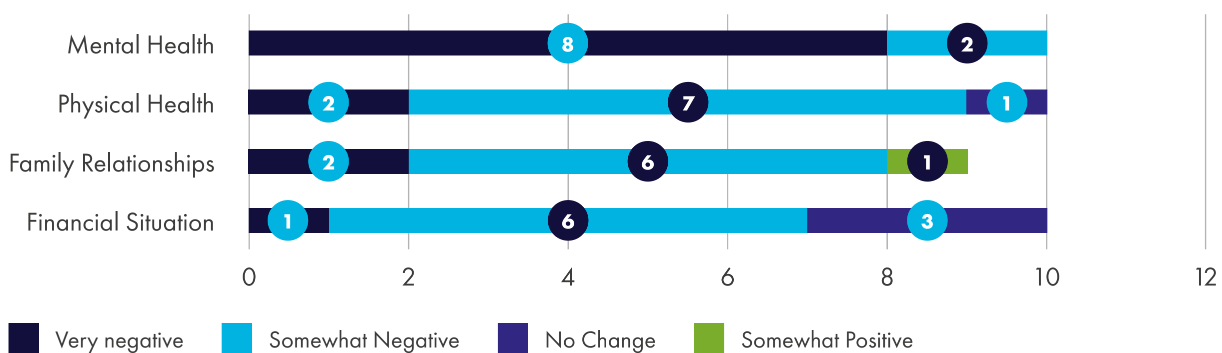
Similar to other recent studies (May et al., 2022; Bennett et al., 2021; Vasylyeva et al., 2021), it is clear that the most affected clients appeared to be those who experienced the most structural oppression, socio-economic inequalities and stigma in the homeless community and/or injected drugs and/or were dependent on substances. The incompatibility of infection control measures with these peoples' needs was emphasised by providers and family members with relatives within the homeless community. For example, maintaining social distancing, street begging, temporary suspension of statutory services and requests to isolate were particularly problematic for this group given the daily necessity of accessing drugs and

resources. In this context, participants believed the pandemic had highlighted and exacerbated structural oppression and discrimination toward this community mitigating their access to services which needed to be addressed going forward.

> *I think [the pandemic] has really highlighted the fact that those individuals and groups [homeless community and people who inject drugs] are really on the periphery of society they're really not included [...] there's not enough cognisance given to how things impact on that client group. [...] There was blatant discrimination of those individuals [...] So I think that client group really didn't get a fair craic and it heightened and highlighted for me the structural oppressors of people who for whatever reason can't necessarily speak for themselves and I don't mean that they're vulnerable and they don't have capacity, I mean just the nature of their daily lifestyle means that's not always possible and priorities are elsewhere.*
>
> Extern

In the provider survey, NIADA organisations were asked to indicate the extent to which the pandemic had negatively or positively affected change to the issues presented in Figure 10 for their clients. Discussion on results is presented in the following subsections of the report.

Figure 10: Service Provider Reports on Impacts of COVID-19 on Clients' Health and Well-Being



This graph excludes 'don't know' responses

4.2 Mental Health

As illustrated in Figure 10, all providers reported substantial negative impacts of COVID-19 on their clients' mental health. In the client survey, participants were asked how their mental health had generally been throughout the COVID-19 pandemic and during the past four weeks.

Figure 11: Clients' Mental Health During the Pandemic

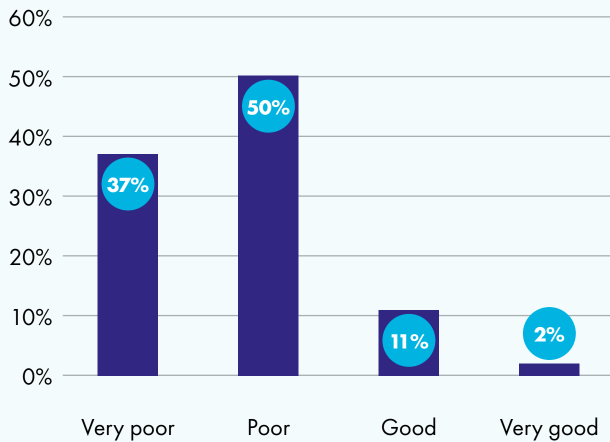


Figure 12: Clients' Mental Health During Past 4 Weeks

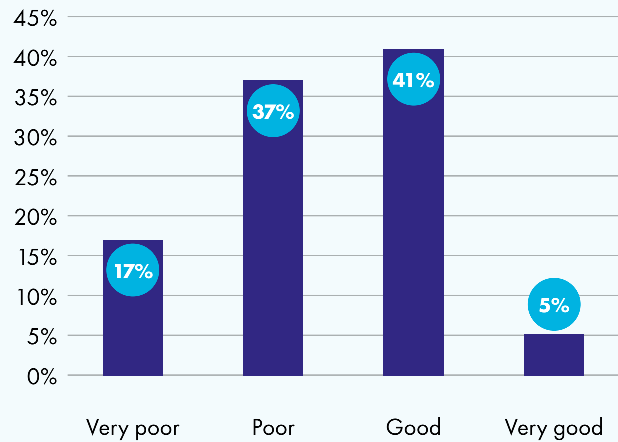


Figure 11 illustrates that 87% reported poor general mental health throughout the pandemic (poor=50%; very poor=37%), compared to 13% reporting positive mental health (good=11%; very good=2%). Contrastingly, the ratio between poor and good mental health reduced when asked about mental health during the four weeks prior to survey participation. Figure 12 shows a drop in the percentage reporting poor mental health to 54% (poor=37%; very poor=17%), while positive mental health increased to 46% (good=41%; very good=5%). This finding contrasts to Higgins et al.'s (2020) research which reported 65% of participants had 'poor or very poor' current mental health, with 35% reporting 'good or very good' mental health. The difference is most likely connected to the research being conducted at a later stage in the pandemic when restrictions were lessening, potentially decreasing some adverse impacts on mental health.

People aged 18 to 25 years were more likely to report poor/very poor mental during the pandemic with 94% of this age group doing so; those aged over 61 years were least likely (60%). Regarding recent mental health, people aged 26 to 35 years were more likely to report poor/very poor mental health and those aged over 61 years least likely.

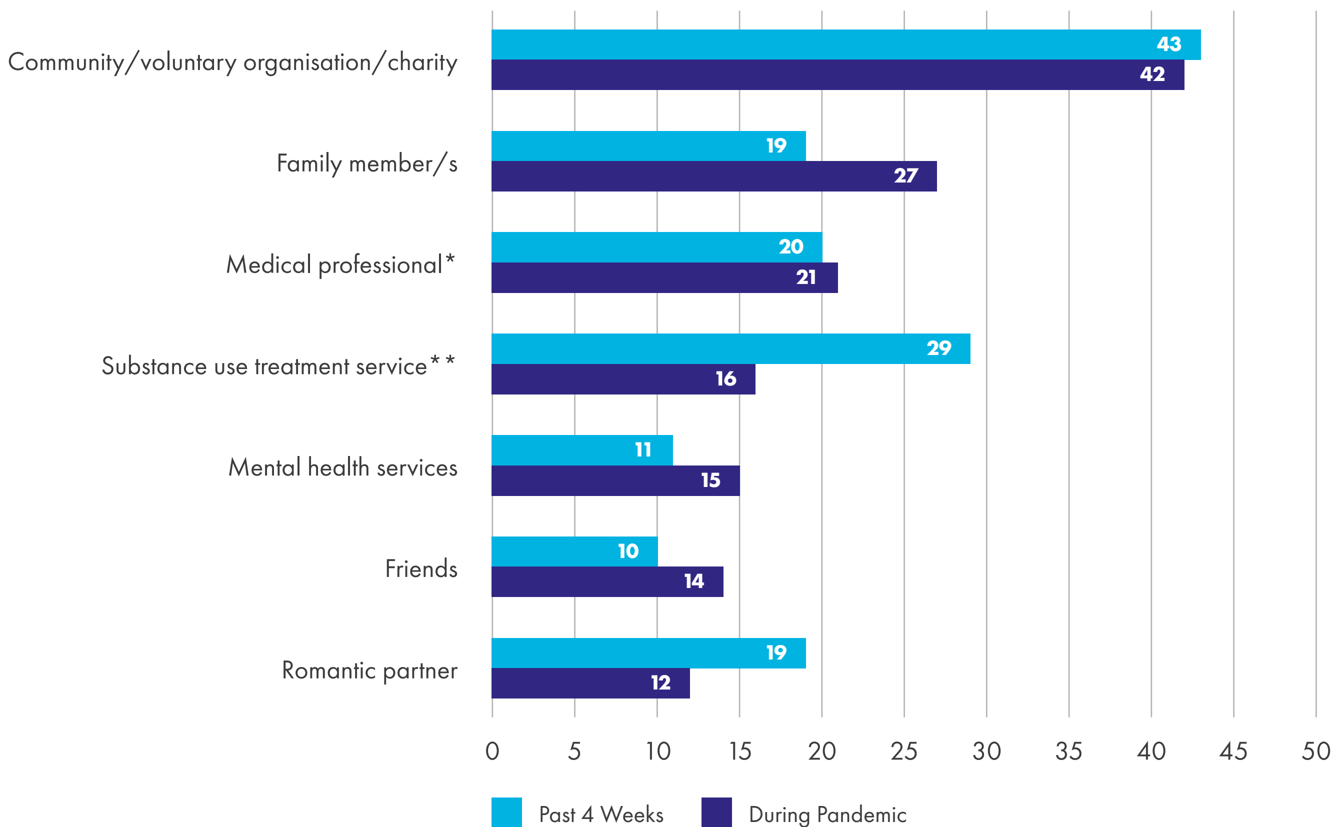
As the sample size is small, caution is needed when interpreting significant results. However, there was a weak significant relationship between gender and mental health in the current study.[7] More women (78%) reported poor mental health in comparison to men (53%) during the pandemic. Similar to Etheridge and Spantig (2021) UK research, this finding is likely linked to increased pressures of family and caring responsibilities given home-schooling and increased exposure to loneliness.

There was also a moderate significant relationship between employment status and mental health over the past four weeks.[8] People on benefits (83%) were more likely to report poor mental health in comparison to students (15%) and those in employment (2%). These findings link with existing research indicating that people experiencing high levels of socio-economic deprivation were the most adversely affected by the pandemic (British Academy, 2021).

Clients were asked if they had received support for mental health during the pandemic and the past four weeks and could select multiple answers. Most clients reported receiving support during the pandemic (61%) and slightly more reported support in the past four weeks (70%). Of those who had reported poor/very mental health throughout the pandemic, 62% reported receiving support while 54% reporting good/very good mental health received support. During the past four weeks, 75% with poor/very poor mental health had received support, slightly lower than Higgins et al.'s (2020) figure of 81%. Of those reporting good/very good mental health, 64% received support. The increase in recent mental health support may be connected to more engagement with services and perhaps the resumption of some face-to-face services. It could also be linked with the lifting of lockdown restrictions during fieldwork for the study.

[7] Recoded into 2 categories for poor and good mental health.
[8] Recoded into 2 categories for poor and good mental health.

Figure 13: Sources of Support for Clients' Mental Health During the Pandemic and the Past Four Weeks[9]



*E.g., doctor, nurse, social worker; **E.g., alcohol, drugs, OST, in-patient.

Figure 13 presents sources of support which helped clients cope better with their mental health during the pandemic and the past four weeks. Participants could choose more than one option. During the pandemic and the past four weeks, the most cited source of support was the voluntary and community sector. This finding highlights the continued reliance on this sector instead of the statutory services to provide mental health support (also found by Higgins et al., 2020) given the prevalence of dual diagnosis which is less likely to be addressed in primary care or acute services.

The second most frequent source of support during the pandemic was family members. However, the number citing family support decreased in the context of support over the past four weeks and was replaced with substance use services. This replacement may be connected to increased engagement with services and statutory substance use services were reinstated during the client survey stage of this study. While not graphically displayed, a smaller number of participants cited support from sporting activities, government agencies and with housing or financial/legal aid costs.

Client survey participants were also asked if there was any other support that would currently help them to cope better with their mental health and 16% (n=16) responded. Comments clustered around engaging with statutory mental health services (n=9), more community and wellbeing groups for young people and adults (n=5) and medication (n=2).

Qualitative findings also strongly emphasised adverse impacts of the pandemic on mental health with variation evident. Three main interrelated mental health themes were identified: increased anxiety and depression; difficulty coping with social isolation; and constrained access to mental health services.

[9] The graph is based on the number of responses and not percentages.

4.2.1 Increased Anxiety and Depression

In the provider survey, NIADA organisations were asked to rate adverse outcomes related to the pandemic. Increased levels of anxiety and depression was identified as the most prevalent and impactful adverse outcome by all NIADA organisations similar to the World Health Organisation (2022) findings. While qualitative findings also strongly emphasised this impact, variations were evident and related to clients' support network, employment status, levels of resilience and extent of engagement with services and diversionary activities.

Providers and clients reported that while the first lockdown had created fear and anxiety for some people using services, others had found initial restrictions and remote delivery beneficial given pre-existing social anxiety.

> *For some people, actually maybe those who have social anxiety, lockdown was a benefit because they didn't have to come out and see anybody.*
>
> ASCERT Adult Services

> *I think when everybody was still coming to terms with it, I was anxious and I was definitely using gear [heroin] because, do you know what, everything's all fucking mad.*
>
> 08, Male Client, early 50s

Subsequent lockdowns provoked a sense of weariness for some people. This sentiment was related to missing social and human connection despite having good social support networks and engagement with services which subsequently increased levels of anxiety and depression.

> *The second wave, a lot of clients have been very weary, I think their drug use has escalated quite a wee bit.*
>
> ASCERT Youth Services

> *The second lockdown was tough. It was winter, it was just that time of year. People had started giving up hope and you could feel that the second lockdown was harder on everybody really. But it was then when I noticed that I developed anxiety Julie, to the extent where it was interfering with my day-and-day doings. Like everything that I've been through I've never had anxiety like this, I have been street homeless, I have slept on the streets of [place in NI] and I haven't experienced an anxiety the way I did during the second lockdown.*
>
> 19, Female Client, early 40s

> *I always thought I was quite good at staying at home and when lockdown came in and everything closed, I thought ,'Yeah, this just suits. There's nobody telling me to go out, there's nobody telling me to go for a walk, there's nobody, nobody putting pressure on me to do anything.' And I quite rightly thought, 'Brilliant, I'll be able to do this'. Seventeen weeks in, I wasn't so good anymore. I thought I had a Masters on this, but it was starting to get hard and [...] So, 17 weeks in I was starting to miss that human connection and I didn't think I would. I thought it would be easy.*
>
> 15, Female Client, mid 40s

Conversely, other adult clients and family members believed that continued restrictions had limited impact on levels of anxiety and depression due to having a good support network including employment, family support and engagement with services. For these people, mental health was more affected by other life stressors which may have been intensified by pandemic restrictions. Cited sources affecting mental health included concerns about relationship breakdown, bereavement, physical health, employment, finances, family conflict, homelessness and continued drug use. Participants variously stated:

> *[Adult child's] mental health is poor. But that was the lifestyle [adult child's] living. It's nothing to do with COVID.*
>
> 03, Family Member

> *I guess during the first lockdown, it was a shock and then you had the second and third, but I guess just feeling fed up about it all. But it didn't have a big impact. I did have support, my [number of] kids and joined an online closed [peer support drugs group] where you could speak to other addicts and that's a really great help, you know, to speak to other people like you.*
>
> 06, Female Client, mid 40s

However, increased and intensified anxiety, depression and suicidal ideation among certain populations of young and adult clients was also emphasised and evidenced with increased dual diagnosis presentations and mental health referrals across all HSCT areas. It was consistently reported that the mental health of socially isolated people was the most adversely affected. This finding is consistent with Higgins et al. (2020) and other European studies which denoted similar rises in anxiety, depression, suicide attempts and increased emergency mental health presentations related to pandemic impacts (EMCDDA, 2021a, 2020).

Adverse impacts on young people were particularly emphasised. Elevated levels of anxiety and depression were linked to school closures, restrictions on meeting with friends, limited family contact, increased family conflict, lack of diversionary activities and low levels of resilience. Subsequently, boredom, overthinking and social isolation affected mental health.

> *I think it's just the days where no one was coming out or anything, I'd nothing to do. You're just sat with nothing to do and then you go on and play your games or something and then that's your sleep schedule messed up. And from that when you're sat at night with nothing to do, and you can't go out or anything and you're sat with yourself and your thoughts. You just keep thinking and thinking and then you start overthinking.*
>
> 02, Male Client, teenager

> *[The pandemic] really actually did affect [child] and mental wellbeing. Being stuck at home and not being able to see friends. [Child] was going out for maybe a walk an hour every day but couldn't meet up with anybody. So [child] was online talking to friends and then doing schoolwork from home and it was all stressful to [child] [...] Just [child] was feeling isolated. The school thing as well, [child] was kind of having to come back into school and feeling as if [child]'s having to start all over again with friends and the friend group, getting to know everybody again and then with the teachers as well. It was crazy, it really was.*
>
> 01, Family Member

> *Young people have been greatly impacted by COVID-19 situations that they've had to deal with in their home life, and even having to deal with that isolation, having to be at home, isolated from their friends, their peers, having nowhere to go, nothing to do.*
>
> Davina's Ark

> *The major thing coming through is anxiety, depression, mental health issues. It's huge. It's already huge. I think definitely in most of the areas, but definitely in the west [WHSCT], we have seen a real detriment of mental health and emotional wellbeing, at all levels [...] And then with young people themselves, when I say young people, I'm talking about up to the age of 25, real, real serious mental health issues, some young people taken off the bridge, young people going missing.*
>
> Start 360

> *We have really seen an increase in suicide, suicidal behaviour. I think it depends on their living situation and the resilience that they have [...] The feedback that we have got, the loneliness, the loss of hope, the isolation from family and they're so isolated already, that has a huge impact.*
>
> ASCERT Youth Services

4.2.2 Difficulty Dealing with Social Isolation

Interrelated with anxiety and depression was the second most prevalent negative outcome identified by the vast majority of providers (90%) in the survey - difficulty coping with social isolation due to pandemic restrictions. In addition to factors already discussed, social isolation was exacerbated for people living in a rural locations with limited access to, or, understanding of, how to operate technology to engage with remote services. Having limited contact with family or friends, losing employment, being furloughed, working from home and/or experiencing homelessness and decreased social interactions and activities intensified social isolation and mental health deterioration. Social isolation and loneliness posed a relapse risk or increased substance use if alternative activities and interactions were not used or available.

> *Certainly, we did see that there was a rise in people with anxiety, with depression and so on. Again very often heightened as well by the fact they were isolated. So many were separated from family members, grandchildren. You know, that interaction they would have had with family and friends, outings with friends would maybe have been the social highlight of their week, maybe going to like the swimming pool or going to PE classes or fitness or meeting somebody for a coffee, and all that stopped, so then they found they were very much at home.*
>
> Davina's Ark

> *There was definite deterioration in mental health. Even things like people who were in rural locations and the fact that they no longer had access to transport, everything was cut off and these are people whose families and probably weren't in contact with them either. So, we did see a deterioration there in terms of their mental health.*
>
> Simon Community

> *The majority of people we would see through the services are not working or not connected to work. So, those groups were very much dependent on what goes on in their communities and what goes on around them to give them some sense of purpose and some sense of connection. So, that has definitely been a factor, isolation from family and friends [...] What we've seen is mental health issues, particularly anxiety, have rapidly increased. So, people are struggling, have struggled with isolation, struggled with lack of contact with others and also struggled in being at home with family members and maybe other people that they didn't necessarily get on all that well with or where they found it a challenge to be in that one place for all sorts of reasons. So, we've seen, I would say about 70-80% of our clients now report an underlying mental health problem and they've been using something to try and cope with that.*
>
> ASCERT Adult Services

In addition, the Housing Executive response to homelessness during the pandemic subsequently increased the transient nature of the homeless community (NIHE, 2020). Prioritisation to protect the health of the homeless community and comply with infection control measures led to the 'Everybody in' approach towards rough sleeping. This measure increased temporary accommodation placements and use of non-standard accommodation (e.g., hotels and Bed and Breakfast). However, demand for services and disputes over substance use and/or availability of suitable support for placements led to people with drug dependency and complex needs frequently moving between placements in varying HSCT areas. This displacement from support networks combined with problems accessing medication and services negatively impacted on mental health for some clients.

One family member had an adult child who was homeless and substance dependent during the pandemic. She explained how her child was greatly impacted by housing policy. Moving frequently from one HSCT to another substantially affected her child's depression and access to services needed to address substance use and mental health needs.

> *At the beginning of lockdown, the Housing Executive didn't want rough sleepers on the street and at one stage they put [adult child] in an apartment up in [place name] and that's [number of] miles away from anybody and [adult child] was on their own and that isolation between COVID and the isolation of being put away from anybody that [adult child] knew, that's not gonna help anybody get off [substance] [...] It has had a big impact on [adult child]'s mental health and there's no two ways about it [...] It's a downward spiral and because [adult child] suffers from depression, being isolated, that didn't help either. So, I would say, that COVID did have a big impact on [adult child's] and mental health.*
>
> 02, Family Member

> *Because people have been more transient and had to move, those with really complex mental health issues are finding the problem with, and this is where we're really struggling in some ways, access to the range of medication. So, for example, somebody with schizophrenia who's been moved to a different hostel hasn't had a doctor in that area. So, a lot of our work has been linking in with other services, GPs, social workers, whoever we can link in with, to try and keep people stable and safe.*
>
> ASCERT Adult Services

4.2.3 Constrained Access to Mental Health Services

Given adverse mental health impacts, providers, clients and relevant family members were frustrated with the lack of dual diagnosis services, long waiting lists to access statutory mental health services and people being released with limited or no support plans following emergency mental health presentations at hospitals during the pandemic. Reduced mental health services during the pandemic has also been noted in European findings (EMCDDA, 2021a). In Northern Ireland, the reduction placed more strain voluntary and community services (Higgins et al., 2020). A number of participants discussed the impact on clients:

> *They're seeking help, they're not getting it, and they don't get help until a point of crisis, and it's our guys [staff] who are the ones who are engaging with them on a daily basis. They're getting presented to A&E, half-times they may stay around for eight hours or more until somebody assesses them and then they may be admitted or they may not and then they're just returned to whence they came, whether that's the street, whether it's temporary accommodation they've been placed in by the Housing Executive, or, you know, myriad circumstances, their own homes too, but they don't have any of the support.*
>
> De Paul

> *You'll have a young person who's been referred to mental health, they're working with you and they're doing great, and they're referred to mental health, but it's taking that long to get into mental health they've probably relapsed quite a few times and they're not great. Then mental health are like, 'They need to address their alcohol use before they get into mental health.' And it's just one vicious cycle.*
>
> ASCERT Youth Services

> *The other frustrating thing that we've seen, especially over COVID, is where people are just discharged from mental health, statutory mental health services with no support, no plan, haven't contacted anywhere, nowhere to live, and organisations like ours are left holding the risk going, 'What do we do about this?' [...] We will not drop that person because we will not do that, it's not what we do, it's not what our staff do, it's not part of our work, and it's really, really frustrating.*
>
> Start 360

All family members expressed increased need for mental health services for their children during the pandemic. It was noted that waiting times to access these services existed before the pandemic but were exacerbated due to issues with staffing and referrals. Frustrations with access to GPs, mental health services and lack of dual diagnosis services were emphasised.

> *I think that lack of being able to get any contact into services, even being able to talk to a GP or go to see a GP has had a big impact. And I know there were quite a number of times during the lockdown periods that [adult child] would have gone to hospital and they'd have just left them sitting in a chair. [Adult child] wouldn't even have had an admission [...]. [Adult child's] actually even been admitted [to mental health ward] to be sectioned but they won't do that when [adult child] has alcohol in his system or if it's alcohol related. They won't take the depression seriously.*
>
> 02, Family Member

A client who was engaged with statutory mental health services before the pandemic also felt frustration that the suspension of some services and continued pressure with new referrals was preventing service reinstatement.

> *[Statutory mental health nurses] were redeployed to the wards or were taken back to do office work within the mental health department. So, they weren't able to deliver the Zoom meetings with us. So, that all stopped [within statutory mental health service] and hasn't started back up again. We don't know when, we haven't heard any word. There's obviously been a big influx of referrals to mental health, which they are needing, quite rightly, to deal with, and I'm at a stage where I can understand their mental health at the minute might be more fragile than mine. And I can understand that these new people need the time and their expertise but that doesn't mean that I don't miss it.*
>
> 15, Female Client, mid 40s

4.3 Physical Health

Figure 10 showed how most organisations (90%) also observed substantial negative COVID-19 impacts on physical health for clients. Only one organisation reported no change. In the client survey, participants were asked how their physical health had generally been throughout the COVID-19 pandemic and during the past four weeks.

Figure 14: Clients' Physical Health During Pandemic

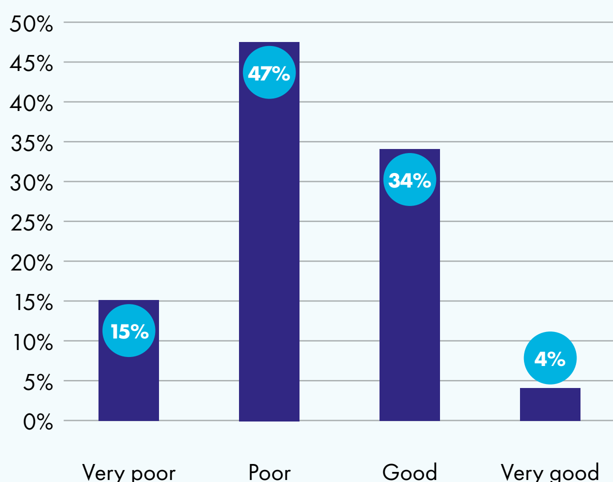
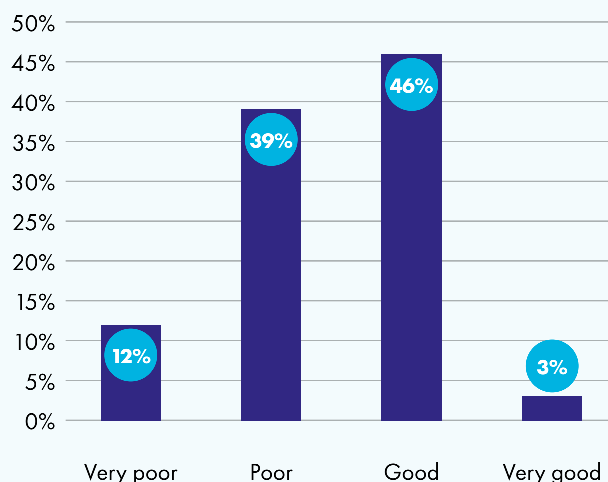


Figure 15: Clients' Physical Health Past 4 Weeks



As illustrated in Figure 14, 62% of NIADA clients reported poor general physical health during the pandemic (very poor=15%; poor=47%) compared to 38% who reported positive physical health (good=34%; very good=4%). Similar to the mental health results, the difference between poor and good physical health lessened when participants were asked about physical health during the past four weeks. Recent poor physical health decreased to 51% (very poor=12%; poor=39%), while good physical health increased to 49% (good=46%; very good=3%) - this is slightly less than Higgins et al.'s (2020) finding of 55%. The current results may relate to the lifting of infection control measures on gyms and other leisure activities and easing of social distancing regulations during data collection mitigating poor physical health.

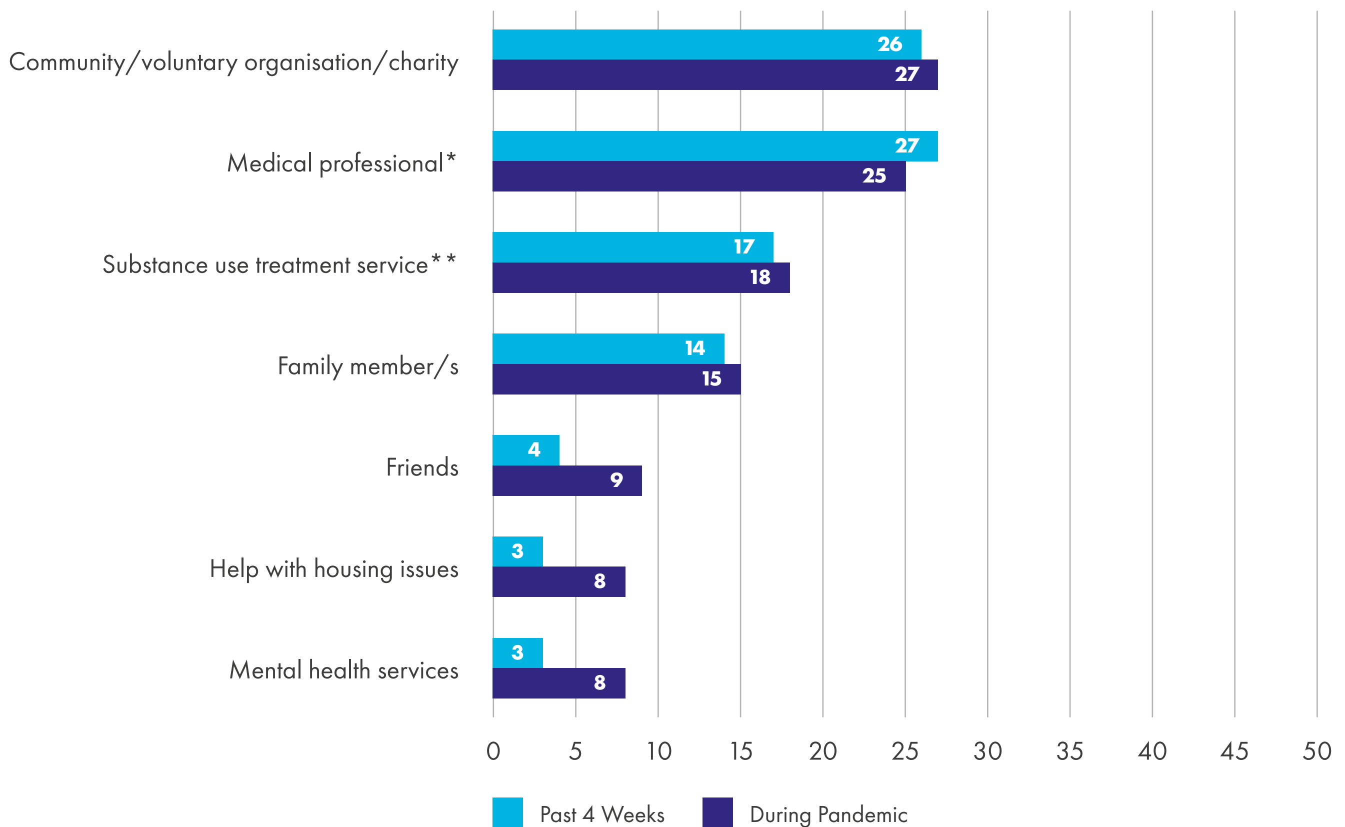
As previously stated, caution is needed when interpreting significant results due to the small sample size of the client survey. There was a weak significant relationship between gender and general physical health[10] throughout the pandemic with more men (71%) than women (44%) reporting poor/very poor physical health. Employment status also had a weak significant relationship with general physical health during the pandemic. People on benefits (70%) were more likely to report poor/very physical health in comparison to students (38%).

During the past four weeks, people stating good physical health were significantly younger than those reporting poor/very health and people aged 18 years and younger (86%) were more likely to report good physical health. These results suggest that there is perhaps a need for more physical health services for adults, particularly men, and people on benefits. The results are likely related to the number of NIADA services providing assistance to young people participating in this study who would be more likely to have good physical health.

NIADA clients were asked if they had received support for physical health. Over half (52%) reported receiving no help during the pandemic and in the past four weeks. Of those who reported poor/very poor physical health during the pandemic, 54% received support, while 38% with good/very good physical health received support. Slightly higher percentages were found for physical health during the past four weeks. Of those reporting poor/very poor physical health, 56% received support which is lower than the Higgins et al.'s (2020) finding (66%). Of those reporting good/very good physical health, 40% had received support. The increase in recent support may be related to the reopening of leisure centres and other activities which had been affected by infection control measures.

[10] Recoded into 2 categories for poor and good physical health.

Figure 16: Sources of Support for Clients' Physical Health During the Pandemic and the Past Four Weeks[11]



*E.g., doctor, nurse, social worker; **E.g., alcohol, drugs, OST, in-patient.

Figure 16 reports sources of support for clients' physical health during the pandemic and the past four weeks. Respondents could choose more than one option. The most cited source of physical health support was the community and voluntary sector. By comparison, Higgins et al. (2020) found that support was mainly from medical professionals. In the current study, support from medical professionals was the second most frequent source of support, followed by substance use services. The number of respondents citing support from family members was consistent during the pandemic and in the past four weeks (at about 15%). Although numbers were small, more respondents reported friends as a source of support during the pandemic compared to the past four weeks (9% and 4% respectively).

A similar picture emerged with regard to help with housing issues and mental health services (8% during the pandemic and 4% in the past four weeks for both). Additional cited sources of support were romantic partner, sporting activities, financial legal aid and support from government agencies.

People who use services were asked if there were any other sources of support that would currently help them with their physical health and 10% (n=10) responded. Comments clustered around more exercise (n=5), mental health support (n=4) and a balanced diet (n=1).

[11] The graph is based on the number of responses and not percentages.

Similar to the client survey results, qualitative data revealed both positive and adverse impacts of the pandemic on physical health. An interesting finding from providers was that despite initial fears about the direct effects of COVID-19 on people in hostels, residential and in-patient treatment settings, these concerns failed to materialise during the first and second lockdowns. Organisations working in this area attributed virus containment to the close social networks of these populations and adherence to infection control measures:

> *Ah, the guys at Stella, we're so proud of them, because the one group we were concerned about more than any other from a vulnerability point of view would have been our Stella clients, even just through compromised immune systems and complex health issues after 30, 40 years, in among other things, and neglect, and also how they would respond to being required to stay in when they're fairly free-spirited, a lot of them. Phenomenal, they kept safe, they complied, our incident levels went through the floor, they showed real respect for one another. I was so, so pleased. Not one significant case of illness throughout.*
>
> De Paul

Other organisations working primarily in recovery/relapse prevention and early intervention services and some clients also noted positive impacts of the pandemic on some people's physical health. Increased care of physical health was linked to lockdown restrictions allowing space to recover from other illnesses, taking up 'online yoga' (15, female, mid 40s) to help with mental health, a lack of alternative social activities, and not being able to access certain drugs.

> *Whenever I couldn't get access to, like, drink and weed and stuff, I'd need something to do, so I started just going on runs and stuff that, started losing weight, and started eating healthy.*
>
> 02, Male Client, teenager

> *I think in a lot of ways, the COVID pandemic was of benefit to my physical health [...] And that's the strangest thing to say, in that it allowed me time to recover quietly and peacefully.*
>
> 11, Male Client, mid 50s

In relation to adverse COVID-19 impacts on physical health[12], providers, some clients and family members reported harms due to gyms closing, lack of exercise, weight gain, decreased hygiene, increased nutritional needs and anxiety affecting sleep patterns and nightmares.

> *Because they weren't able to get out and about as much, they weren't keeping as active. Things too due to the anxiety and so on that they had as well, their sleep hygiene was greatly impacted. People who maybe would have slept soundly during the night were suddenly suffering from insomnia, disrupted sleep patterns, nightmares, flashbacks even as well, things that had happened. Because with everything shutting down, there was then that space for a lot of things that people had been through in the past to come back up to the surface. Some of our service users as well would maybe have relied on fast food outlets, or takeaway places, and, of course, during the first lockdown all of that closed. So then they were left with 'Right, what am I going to make for myself? How am I going to cook?'*
>
> Davina's Ark

> *With the restrictions and staying indoors myself, I've put on a bit of weight, lack of exercise, going to the gym and that sort of thing.*
>
> 10, Male Client, mid 40s

Two family members also noted that adverse physical health due to pandemic infection control measures negatively affected their children's mental health.

> *[Adult child] put on a lot of weight. When [adult child] was with me, [adult child] had joined the gym so that helped mental health and of course with the gyms closed then that wasn't happening. So, all [adult child] was doing was constantly drinking, constantly smoking. It's a downward spiral and because [adult child] suffers from depression, being isolated, that didn't help either.*
>
> 02, Family Member

[12] Several injecting drug use related harms were reported and are discussed in Section 5.3.5.

In addition, the strain of COVID-19 on other primary health and social care services resulted in appointment delays for some clients' existing physical health needs which affected mental health.

> *Obviously, we would have a pretty significant proportion of the client group that would be older and they would have some kind of physical health issues already. Particularly those who are living with cancer, their appointments were obviously postponed and put off, which kind of triggered mental health and anxiety and depressions about the prognosis for them long term.*
>
> Simon Community

> *Physical health wasn't great before the pandemic and has been pretty shitty throughout. And then you have the longer hospital waiting times, just the kind of exams I could go for and stuff like that was just hindered.*
>
> 16, Male Client, early 40s

However, three clients with severe physical health conditions did not experience any delays receiving treatment from primary health and social care services. One stated that:

> *I would say that the [pandemic] impact on all of my appointments, of which there were a phenomenal amount, was actually of more benefit, doing Zoom meetings and also access to hospitals, all of that there, for me, were superb, couldn't, couldn't have been better.*
>
> 11, Male Client, mid 50s

Providers reported that while GPs continued to deliver advice via phone to clients, instructions to attend accident and emergency services for physical health issues were sometimes met with reluctance given waiting times and concerns about judgmental attitudes towards their drug use and related physical harms.

> *With the GPs directing more people towards either phone contact or going to A&E, people were reluctant even, because their experience of going to A&E would be fairly negative, you know, waiting around and the impersonal side of that, that things that they maybe would have got checked up on went unchecked and undiagnosed.*
>
> Simon Community

4.4 Family Relationships

Figure 10 highlights that most providers (80%) also reported substantial negative impacts on family relationships, with one organisation noting a somewhat positive impact. Qualitative findings also indicated adverse impacts on family relationships dependent on whether people were using substances during the pandemic and engagement with family and/or substance use services.

A strong qualitative theme was that some family members' drug use and associated mental health issues became more visible due to lockdown restrictions which escalated tensions, conflict and relationship breakdown for some clients.

> *What we also noticed was a great increase in the number of family members who needed our support, because with the lockdown, what happened was that some of the people in addiction were hiding it from their family members that they were using, that they were drinking, that they were gambling. And then whenever the lockdown hit, and everybody was having to spend so much more time together, all these things then started to come to the surface, particularly with regards cocaine, because usually it would have happened whenever the individual would have been out of the home, possibly in a different social setting and so on. But they'd nowhere else to go, so therefore they were using within their own homes and then were caught out by family members, so the impact of that was huge as well.*
>
> Davina's Ark

> *[Child] was having a wee sneaky drink at the weekends and [child] maybe got caught on but [child] was actually starting to do it from home to the point where [child] was going and helping [themselves] to any alcohol that was in the house. We thought that [child] was just doing it outside and that [child] could be trusted at home, we kept an eye on [child].*
>
> 01, Family Member

> *More families are wanting support, they're really struggling with their young people's mental health, their sons' and daughters' mental health [...] I think it's because they've been so confined in such a small space, not used to living together. And then young people and young adults are like disappearing for three days in a row and mothers and fathers are just so full of anxiety, anxious, they don't know where they are, they're worried sick.*
>
> ASCERT Youth Services

Conversely, pandemic restrictions had provided space and time for other families to work on their substance use and improve relationships with family members. This was a particularly dominant theme for clients in early or longer term recovery.

> *One gentleman that I work with has reduced his working hours, he no longer does weekends. He's become so much more family-focused, and he himself would admit that, prior to COVID, he doesn't think he ever would have changed how he worked, so I think certainly that's a positive thing.*
>
> Davina's Ark

> *I enjoyed the first lockdown, I had my [children] at home all the time. There was no school and their daddy worked. I was able to work from home, which meant then that the [children] were just left with me every day and I loved it, Julie. I didn't see my daughters for [length of time] and I only started seeing them again [length of time]. So to have that 16 weeks at home with my [children], I couldn't have asked for any better.*
>
> 19, Female Client, early 40s

Providers working with families affected by hidden harm reported mixed impacts. For some families, lockdown restrictions were linked with increased motivation to engage with services and achieve positive outcomes. Conversely, reduced statutory social service intervention and parents being less visible due to decreased participation in routine day-to-day activities exacerbated harm given that some parents had increased substance use during this period.

> *And for some of those families [experiencing hidden harm, social services allowed that parent to return to the home to see if, with COVID, almost like a family support, and for some families that worked really well. And then for others, it was just the worst decision ever, it was just an explosion waiting to happen. But what was frustrating at times was what appeared to be the lack of social services on the ground whenever we were saying, 'This family need a home visit, you need to go out there' and they didn't do it. And you're thinking, 'Come on. We've told you that there's a serious issue there, we need somebody to go out there and do this.' Sometimes that didn't happen, and it was very, very frustrating.*
>
> Start 360

4.5 Financial Situation

Figure 10 shows that most organisations (70%) observed clients' financial situation being negatively impacted by the pandemic, while 30% reported no change. It is likely that differences relate to factors such as employment status and the type of client group engaged with services. For example, low threshold services work with homeless and injecting drug use communities whose income is largely based on social security benefits and begging in city centre streets. As Higgins et al. (2020) and Campbell et al. (2021) found, these clients' income source was substantially affected by lockdowns and social distancing. The decline in opportunities for informal income-generating activities exacerbated material and economic hardship which has been documented in other recent studies (May et al., 2022; Bennett et al., 2021). Consequently, participation in sex work and alternative methods of acquiring money to fund drug use had increased:

> *Obviously for that client group [street homeless, injecting drug use] in particular, the main source of income as such outside of whatever they were getting regularly through benefits and stuff was impacted by social distancing and the fact that mostly the city centre was shut down where people would have been able to access money from members of the public. That was really completely decimated and as a result then the service users became quite desperate [...] I think things like sex working have increased and then borrowing off each other as well. I would imagine there's been other forms of activity that have involved them accessing money [...] I think people took their opportunities where they arose.*
>
> Extern

While three interviewed clients reported no adverse impact on their financial situation due to their self-employed status or continued employment throughout the pandemic, others and NIADA providers reported that poverty and socio-economic deprivation had increased. Restrictions meant some people were furloughed or lost jobs resulting in debts and being unable to pay for food and other essential items. While services tried to help people with these issues, sometimes financial challenges increased acquisitive crime rates and participation in drug distribution.

> *There is a lot of poverty. People have been furloughed, people have lost their jobs, the impact of that, people are losing their homes [...] We are finding clients who can't afford to eat, they're not eating. We're doing everything, trying to get food packs out to them [...] So there's a lot of financial stressors there too which then increases crime rate as well [...] So, it has had a real knock-on effect with a lot of young people and adults and their families.*
>
> ASCERT Youth Services

> *Increased dealing due to loss of part-time work to support own heroin use.*
>
> Simon Community

> *The third lockdown was the worst, I was put out of work, I couldn't work, I couldn't earn money, I just couldn't make ends meet, which was worrying like. I'm working again now, I'm working like six days a week, I have to work, there's nothing I can do. Look, I have to do things to get by.*
>
> 06, Female Client, mid 40s

4.6 Other Adverse Outcomes Related to COVID-19

In the provider survey, practitioners were asked to what extent their clients experienced the below adverse outcomes due to the pandemic.

Figure 17: Service Provider Reports on Clients' Adverse Outcomes Related to COVID-19

This graph excludes 'don't know' responses.

4.6.1 Increased Domestic Violence

Most providers (90%) reported an increase in domestic violence for some clients, with 30% stating a high increase although this was not reported in qualitative interviews with clients and family members. Providers associated the rise with lockdown restrictions and increased drug consumption exacerbating conditions for domestic violence.

> *We saw a spike in domestic violence in conjunction with increased alcohol consumption and substance abuse. And in some cases, this is people who were potentially in relationships where they had not lived together. Either the relationship was in its early stages, or indeed, was a multi-year relationship but it was fractious enough that they never lived together, but these individuals made choices to live together because of the imposition of lockdown, and in some cases it ended extremely badly and in one instance a murder investigation.*
>
> De Paul

> *One of the things that has been highlighted too is domestic violence. And that's where the hidden harm has come in too. So we're really trying to introduce steps to cope and to work with the young people. As I said there about that tightknit, all living under one roof, the domestic violence which is coming out and maybe abusive relationships and that's through family relationships and partner relationships as well. And that is really concerning too that a lot of young people and young adults are actually living in all this and a few of the clients have been made homeless too because of it.*
>
> ASCERT Youth Services

4.6.2 Increased Overdoses and Drug-Related Deaths

Most providers identified drug overdoses (70%) and drug-related deaths (60%) as an adverse outcome for clients during the pandemic (see Figure 17). Family members, clients and some organisations who were interviewed did not have direct experience of these issues during the pandemic. However, practitioners working in day/drop-in centres and hostels recalled that during the first lockdown there was a decrease in overdose rates among relevant client groups, a finding also reported by Higgins et al. (2020) and Campbell et al. (2021). This downward trend was related to reduced movement, resources, drug use and compliance with COVID-19 restrictions.

> *In the hostels we had ourselves prepared for an increase in chaotic drug use and potential overdose as a result. But when we actually look back on it now, we saw that almost the opposite happened. There was a greater level of stability than we would have had, our rate of overdoses actually went down and this going back to middle of March when the first lockdown came right up until the summer, kind of the end of May, when we started to see the numbers of overdoses come back to where they would have been pre-kind of-lockdown. Now part of this, we're trying to kind of make assumptions, there's nothing scientific behind any of this, but there was certainly reduced movement, reduced access to money at times. So there was people who would have maybe traditionally have gone in and begged or whatever, so there wasn't the footfall in town for them to have access to money. I suppose people did adhere to the restrictions more than we would have assumed as well. There was those who didn't, but we probably had greater adherence to, you know, to the restrictions than we would have anticipated as well and, as a result, people just weren't using as much [at the start of lockdown].*
>
> Simon Community

However, overdose rates increased during subsequent lockdown periods:

> *We've had naloxone administrations, sometimes four to five in a day, and sometimes daily, all around, it's not just about the pleasure of getting high, a lot of it is to mask the underlying emotional issues that these people are feeling. To feel nothing, exactly. And it's exploded, if you look at the number of instances we've had over the past 12 months versus the years that preceded it, it's unrecognisable. And then you've a staff team who's stretched beyond reasonable expectations and how they respond to that. I've worked in homelessness services for 26 years and when I started out, the idea of having to respond to an overdose, it may have happened once in about five years, and it was a crisis and talking point for days after. Now people are dealing with it daily and they are actually providing medical intervention through the administration of the drug naloxone which stops that person from experiencing respiratory failure and just expiring before your eyes.*
>
> De Paul

Other organisations reported increased rates of overdose and drug-related deaths throughout the pandemic in community settings. Reasons for elevated numbers were linked to social isolation, lengthy waiting times to access OST and other statutory substance use services, periodic difficulties accessing preferred substances, trying different substances, increased levels of polydrug use and higher or inconsistent purity levels:

> *Now, at the beginning of lockdown there were issues around, for example, accessibility of cannabis and other drugs. And so what happened is we noticed people mixing and matching more, turning more to prescribed medication, not necessarily even their own, maybe somebody else's in the family [...] And also people experimenting with drugs, because they weren't using, weren't getting their regular whatever it is, they've been trying anything and everything to get the same effect. So, the result is [...] there have been deaths over the year, accidental overdoses mainly rather than suicides because people have been engaging with polydrug use and have no idea what they were taking. [...] PBNI [Probation Board Northern Ireland] clients because of the nature of them there's a huge amount of trauma and underlying issues going on for those guys. So, unfortunately they would be a service where there'd be quite a bit of loss over the year, I mean, it's not far off one client a month, I reckon, accidental overdoses or deliberate, simply because so many factors coming into their lives and, again, they're reaching out and trying all sorts and anything to try and cope.*
>
> ASCERT Adult Services

> *The appearance of ever more potent benzodiazepines during the pandemic appears to have been a factor in a number of fatal overdoses, mirroring the situation in Scotland. When combined with opioids, alcohol and gabapentin, the threshold to fatal overdose is lowered.*
>
> Extern

> *Changes in quality or purity of substances has been more erratic than usual [...] The inconsistency of substances has led to increased risk of overdose.*
>
> Regional Service User Network

Some organisations reported some younger clients became less risk-adverse during the pandemic. This finding is similar to developments reported by Higgin et al. (2020) and Campbell et al. (2021). Restrictions had exacerbated risk-taking behaviours, particularly for those who were street homeless and injected drugs. Contributing factors increasing overdoses and drug-related deaths were reductions in physical, enclosed spaces for injecting and more public injecting in remote locations given increased visibility in city centres. Extern spoke of the:

> *[I]ncreased ambivalence to risk, 'If I die, so what?' thinking. This increases the severity and frequency of risk taking [...] Using drugs in hazardous and hidden locations such as under bridges, in scrub land. These would make it far more difficult to notice an overdose and riskier to respond to it if you did see it.*
>
> Extern

4.6.3 Increased Drug-Related Intimidation and Violence

Figure 17 highlights that 60% of providers observed an increase, with 10% reporting no increase. However, there were mixed reports from providers regarding increased drug-related intimidation and violence among clients due to issues associated with drug debts and markets. These differences are likely connected to differing client groups, some of whom may be more prone to intimidation and violence within drug markets as they are actively using drugs in comparison to those who are not. While qualitative data from clients and family members did not address this issue, some providers noted increases in people being 'put out of their areas and had to move' (ASCERT Adult Services) to different locations by either local communities or paramilitary organisations. Similar to Higgins et al. (2020) and Campbell et al. (2021) findings, one organisation noted that some clients were 'at times agitated, at times aggressive' (Extern) given increased concerns and conflict over financial resources, accessing drugs and drug debts.

5. Impacts of COVID-19 on Drug Markets, Use and Related Behaviours

This section presents results on the impacts of the pandemic on drug markets, use and related behaviours from the perspective of NIADA providers, clients and family members. As drug availability in local markets affects drug use patterns, discussion firstly focuses on the impact of the pandemic on drug markets, followed by patterns of substance use and related behaviours.

5.1 Drug Markets

5.1.1 Access, Cost, and Quality

NIADA organisations were asked to indicate if they had heard reports from clients or other providers about access to drugs, purity and cost since the start of the pandemic in March 2020.

Figure 18: Service Provider Reports of Changes to Access, Quality and Cost of Drugs since the Start of COVID-19

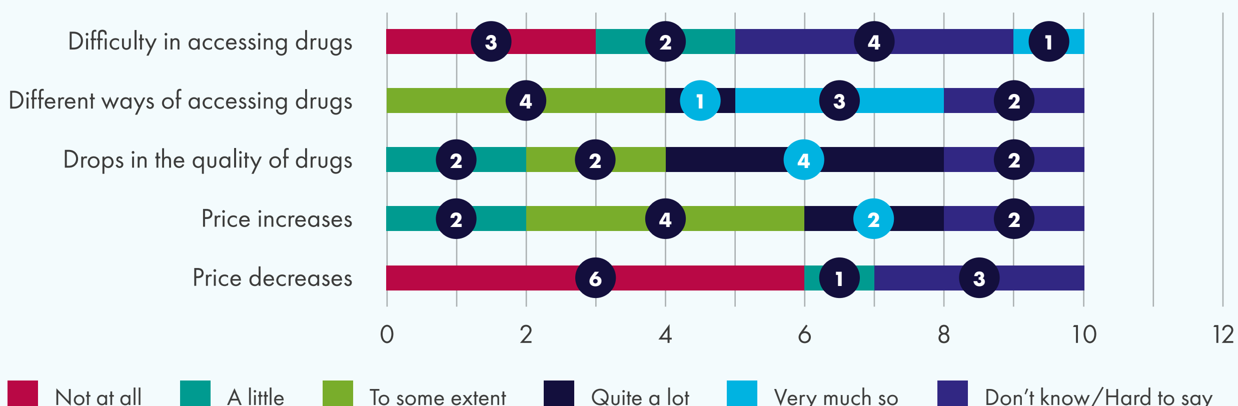
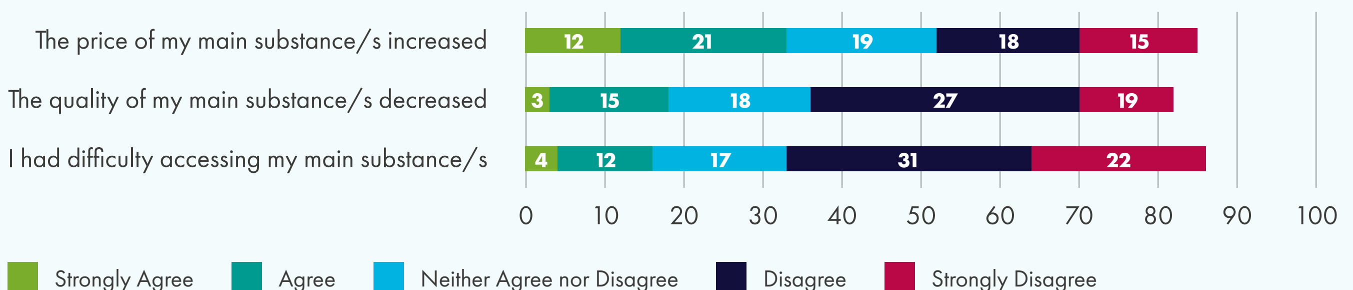


Figure 18 highlights that 30% of providers observed clients having no difficulty accessing drugs throughout the pandemic, while 60% reported little to some difficulty and 10% reported a lot of difficulty.

Most providers reported people using different ways of accessing drugs during the pandemic. The majority (80%) also observed a drop in the quality of drugs and 90% reported price increases. Conversely, 10% observed small price decreases.

Figure 19: Client Reports of Changes to Access, Quality and Cost of main drugs during COVID-19 pandemic[13]



This graph excludes 'don't know' responses.

[13]The graph is based on the number of responses and not percentages.

In the NIADA client survey, participants were asked if they agreed/disagreed with the statements in Figure 19 relating to cost, quality and access to main drugs during the pandemic. Variations in results may be due to the majority (76%) using alcohol as their main substance.[14] In addition, various other main or preferred drugs were reported and different drug markets may have experienced differential impacts of the pandemic. Figure 19 shows that 39% of respondents reported price increases with an equal number, experiencing no increase. Just over half of participants (56%) did not experience decreased drug quality, while 12% experienced a quality drop. Over two thirds of clients (62%) had no difficulty accessing main drugs during the pandemic, while 19% had access issues.

As reported in the quantitative data and previous research (Higgins et al., 2020; Campbell et al., 2021), qualitative findings suggested some fluctuations in accessing certain drugs throughout the pandemic. However, drug markets generally remained relatively stable and resilient similar to the other parts of Europe (EMCDDA, 2022, 2021a). Specifically, access to counterfeit prescription medications (especially benzodiazepines), cannabis, cocaine and heroin were highlighted as affected by the pandemic.

As previously noted,[15] some providers reported 'ever more potent benzodiazepines during the pandemic' (Extern) increasing the risk of overdose reflecting what happened in European drug markets (EMCDDA, 2022, 2021a). Access to specific types fluctuated throughout the pandemic but a steady flow of these substances was reported.

> *We thought there might have been a lack of supply but we didn't really see that. We certainly saw certain substances at times that weren't as available, but there was always something there to replace that. So, we would have had, at particular times, a load of MSJs [diazepam], for example, flooding the hostels or the street Xanax, [diazepam] or different kinds of street diazepam and things like that. So, whatever was available was what people used.*
>
> Simon Community

Providers and clients reported pandemic impacts on the cannabis market, particularly during the early stages of the pandemic which increased cost leading some clients to use other substances (see also EMCDDA 2022, 2021a and Higgins et al. 2020). The Regional Service User Network noted that:

> *The distribution channels had all been disrupted because of the pandemic and cocaine was widely available so you have people, guys who had gone from using cannabis.*
>
> Regional Service User Network

This was also an observation reported by other providers:

> *Now one of the things that was really highlighted to us was the cannabis use. Cannabis was harder to get so therefore they reverted to different drugs, which they wouldn't normally use [...] They [drug suppliers] doubled the price of cannabis.*
>
> ASCERT Youth Services

NIADA clients also noted continued fluctuations in the quality of cannabis and increased price indicating the pandemic was continuing to affect the cannabis market.

> *[Cannabis] prices have increased, availability has been hit and miss [...] I'd say, my original person was very interested in good [cannabis] basically and there was times when I'd phone him up and said, 'Did you get that, what you were after?' And he said, 'No, I don't have a thing.' I said, 'But you said you were getting some.' He said, 'No, I went and saw it but it was rubbish, I wouldn't buy it.' So, he wasn't prepared to do it. However, now in [place in NI] it's, you get whatever yer man has and I don't think he's too bothered about quality control, shall we say.*
>
> 10, Male Client, early 40s

Interestingly, older, experienced clients reported that while herbal cannabis had remained largely available in some form throughout the pandemic, cannabis resin became unavailable for a period of time with the cost remaining elevated suggesting that importing of cannabis resin was and continued to be affected by pandemic restrictions.

> *The change in the cannabis didn't happen for like the first ten or eleven months and then it dried up. I prefer hash to grass you see, but there was no hash.*
>
> 04, Male Client, early 50s

> *You could get grass and stuff but you couldn't get any hashish anywhere and I would only smoke hash. I can get it again now but it's really, really expensive. It's really gone up in price, it's like 80 quid a quarter.*
>
> 08, Male Client, early 50s

[14]See Section 5.2.
[15]See Section 4.6.2.

Most organisations and two clients stated the heroin market remained relatively stable throughout the pandemic. However, there had been periods during the first lockdown when access was difficult and purity affected. Inaccessibility led some people to substitute or supplement their drug use with stimulants and other drugs while others self-detoxed.

> *Changes in quality and purity of substances has been more erratic than usual with many opioid users supplementing their use with stimulants such as crack cocaine.*
>
> Regional Service User Network

> *During the first lockdown, midway [...] there seemed to be a real dip [in heroin availability], and I found it really hard to get [...] The person that I was getting it off regularly just dropped off the map and [...] I couldn't get any other regular supply, so there were longer periods of me not taking it which, which wasn't pleasant but was also just kind of what I needed as well.*
>
> 16, Male Client, early 40s

Older, experienced interviewees who used heroin during the pandemic did not encounter any access issues. One person living in a rural area in Northern Ireland reported an 'always steady' access to heroin with quality and price remaining 'always the same, never changed once' (13, Male Client, early 50s). Another client reported no access, purity or cost issues due to heroin being delivered via the postal service through established contacts.

> *I never had any problem with my [heroin] supply, because I was also using the postal service to get gear sent over, I seemed to always be all right for supply like.*
>
> 08, Male Client, early 50s

A dominant qualitative theme among providers and one family member was the stability of the cocaine market throughout the pandemic. Cocaine accessibility was evidenced though increased availability, decreased cost and temporary constrained availability of other substances contributing towards increased use among certain population groups within specific geographical locations in Northern Ireland. Three providers within the BHSCT and SEHSCT emphasised increased cocaine injection and related harms among the homeless community and those who injected drugs.

> *We did see, at times, particular spikes in cocaine use when cocaine was more readily available than the heroin, for example. We saw people injecting cocaine in greater numbers as well, and people who weren't necessarily injectors prior to this kind of jumping from, you know using pregabalin and Xanax and different things to injecting cocaine. Now that was really kind of Belfast and Lisburn-based, we didn't see broader than that [...] The numbers of those injecting cocaine are relatively small, but in terms of the numbers that we would have seen [before the pandemic], it's a significant increase.*
>
> Simon Community

> *Access to it [cocaine] was easier and it was cheaper to access [than heroin] as well.*
>
> Extern

Some organisations also noted increased use in other populations snorting cocaine approaching services for help during the pandemic. However, it was emphasised that cannabis and snorting cocaine had both become increasingly normalised and socially acceptable in Northern Ireland prior to the pandemic.

> *The likes of say cannabis, these drugs have now become so normalised in our service users that they don't see it as drug taking. You actually have to check with them 'Do you do cannabis?' And even cocaine has gone that way to some extent in amongst some groups, whereby they do cocaine after they have some drinks [...] I think social use [of cocaine] has become more normalised. It's become more acceptable to do cocaine, if you like. It used to be seen as a trendy thing that was done by people who are very well off, or else the other end of the scale, people are completely addicted to it. But now it's in that middle ground [...] Cocaine use is also higher in under 40s and a general trend of usage is growing.*
>
> ASCERT Adult Services

> *Particularly with regard to cocaine, the number of people who were phoning requesting our services with regard to cocaine addiction was huge [during the pandemic].*
>
> Davina's Ark

> *Some people would have said when they came in here that during the pandemic you could have got cocaine, certainly in Belfast, you could have got it delivered easier than an Amazon package to your house.*
>
> Carlisle House and Gray's Court

Other research suggests that these findings should not be surprising (EMCDDA, 2022, 2021a; Higgins et al. 2020).

5.1.2 Selling and Supply

Providers were asked to indicate if they had heard reports from clients or other providers about the impact of COVID-19 on how substances were sold and supplied.

Figure 20: Service Provider Reports of Changes to Sale and Supply of Drugs Since the Start of COVID-19

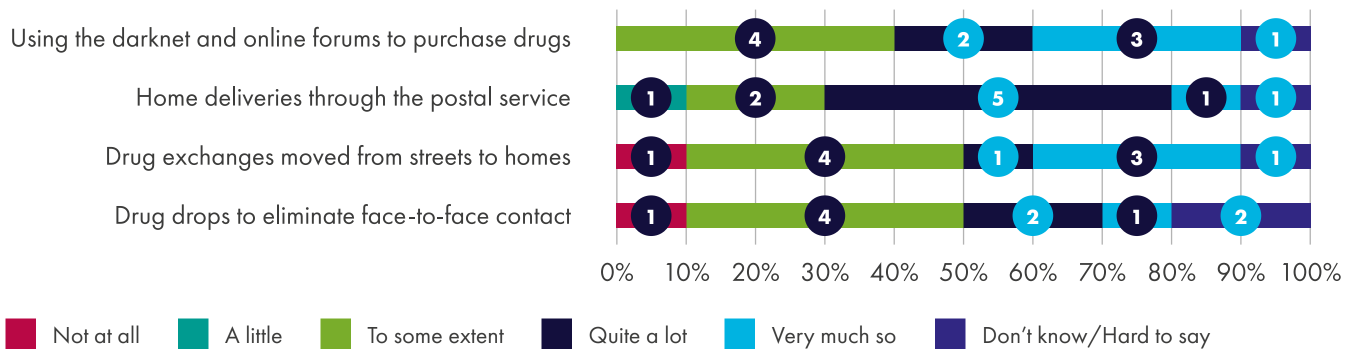
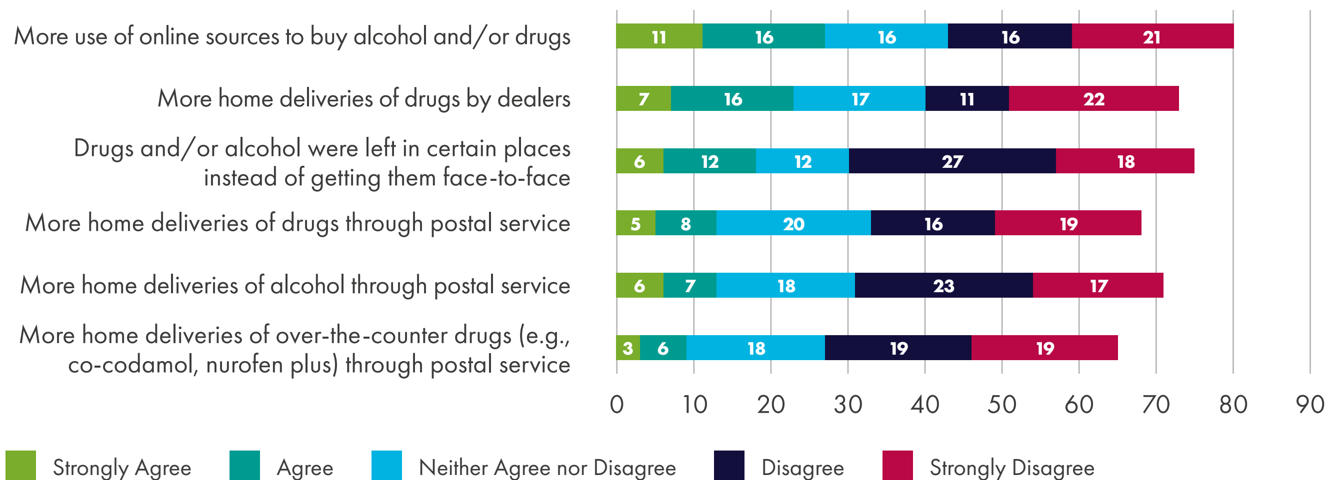


Figure 20 highlights that increased use of the darknet and online forums to purchase drugs was reported by the majority of providers (90%). Ninety percent also observed increased home deliveries of drugs through the postal service.

Most providers (70%) observed an increase in drug exchanges moving from streets to homes and increased drug drops to eliminate face-to-face contact (60%).

Figure 21: Client Reports of Changes to Sale and Supply of Drugs since the Start of COVID-19[16]



NIADA clients were asked to what extent they, their friends and people they know agreed/disagreed with the above statements about the selling and supply of main drugs. It is likely that variations relate to the range of drugs used by participants which may have been affected, if at all, in different ways by the pandemic. Figure 21 shows that 34% experienced or observed more use of online sources, while 46% did not.

Some increases in home deliveries of drugs by dealers was observed or experienced by 32%, with 45% stating no increase. Two thirds (60%) did not observe or experience an increase in substances being left in certain places instead of face-to-face supply, with 24% stating an increase. Over half did not observe or experience increased home deliveries of alcohol (56%) or other drugs (51%) through the postal service. Just under two thirds did not observe or experience more home deliveries of over-the-counter drugs (58%) via postal services.

[16]The graph is based on the number of responses and not percentages.

Qualitative findings noted increased visibility of drug exchanges within street settings due to lockdown restrictions exacerbating the potential for police detection. Subsequently, some street exchanges moved to home and/or postal deliveries of substances.

> *Pre COVID, [drug exchanges were] all very secretive, during lockdowns dealers driving into communities and being seen.*
>
> Dunlewey Addiction Services

> *Whenever it was the first time that people went into lockdown, I was still able to go out and score and things. It was just the streets were empty and I remember feeling a bit odd about how, like if the cops stop me, what was I gonna say and stuff.*
>
> 08, Male Client, early 50s

Given increased risk associated with street exchanges, three providers and some clients noted increased use of online sources and new use of social media applications to sell drugs during the pandemic. Use of surface web applications became a common feature in drug markets in other parts of the UK prior to the pandemic (Moyle et al., 2019). However, the EMCDDA (2022, 2021a) maintain that the pandemic accelerated this drug market adaption evidenced through increased use of encrypted messaging services, social media applications, online sources, mail and home delivery services. Increased use of messenger applications by young people in the current study was emphasised.

> *Whenever COVID hit, most things went from just people hanging about the streets to online and on Snapchats and Instagram's. So, it became you just go text them and get one of your mates that has a bank account set up to transfer money and then that's it landed.*
>
> 02, Male Client, teenager

It was noted by providers that while online buying had been growing in Northern Ireland before the pandemic, surface web advertising through messenger applications had not been previously observed in parts of Northern Ireland.

> *There's been an increase in buying medication, for want of a better word, or drugs, online, a huge increase in that there [...] One of the things actually that happened and that I become aware of was a WhatsApp group that was floating about there and it actually was one run, for want of better words, by drug dealers. And it was listing everything that you could buy and the price of it, so I suppose that's something that we never really come across before. So, they couldn't physically visit their clients, the dealers, but now they're emailing them, texting them and WhatsApp-ing them.*
>
> ASCERT Adult Services

> *We also found that young people had no problem getting drugs during COVID if they had money. It was only a Snapchat away, an Instagram message away or Facebook message away. And it was delivered to your door and you had nowhere to go so if you had money, you had no problem getting access to drugs. So even the people who were dealing the drugs, they adapted their ways of working to meet the COVID need.*
>
> Start 360

5.2 Main and Secondary Drug Use

This section discusses the main and secondary drug use of NIADA clients participating in the survey.

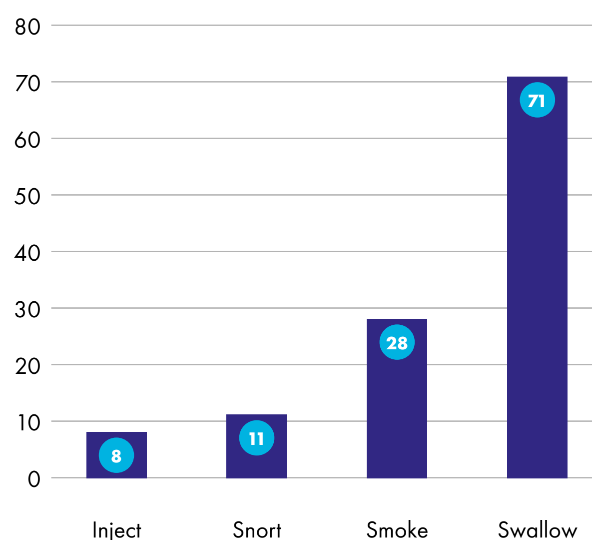
5.2.1 Clients' Main Drug Use

As previously stated, out of the 98 NIADA clients who participated in the survey, 92 (93%) had used drugs at some point since the beginning of the COVID-19 pandemic in March 2020. The other six people (7%) were in longer term recovery for substance use.

Table 2: Clients' Main Drug Use During the COVID-19 Pandemic

Main Drug Use During Pandemic	N	%
Alcohol	70	76%
Cannabis	31	34%
Cocaine/Crack Cocaine	14	15%
Benzodiazepine	12	13%
Pregabalin	11	12%
Heroin	10	11%
OST*	6	7%
Codeine**	6	7%
Other Opioids***	5	5%
Ketamine	1	1%
MDMA	1	1%

Figure 22: Clients' Main Drug Route of Administration[17]



* E.g., Methadone/Subutex/Suboxone/Buvidal; ** E.g., Co-codamol or Nurofen Plus;
*** E.g., tramadol, morphine, dihydrocodeine.

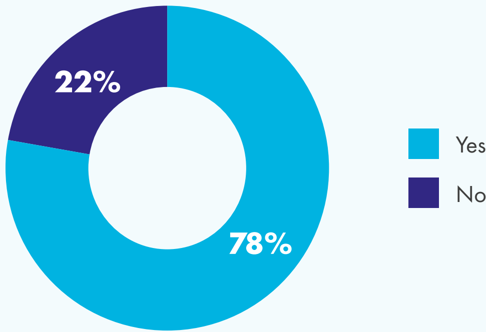
NIADA clients who had used substances were asked what their main drug was during the pandemic. Participants could select multiple response options. Table 2 presents the range of main drugs reported. Almost two thirds (58%) of NIADA clients reported using one main drug, while 42% stated using two or more drugs indicating a rise in polydrug use and an intensified cohort of clients (Higgins et al. 2020; DOH, 2021a).[18]

Similar to current use and Higgins et al.'s (2020) study, Table 2 highlights that the majority reported alcohol (76%) as their main drug during the pandemic. The second most reported main drug was cannabis (34%), followed by cocaine/crack cocaine (15%), benzodiazepines (13%) and pregabalin (12%). These results reflect official statistics on the most prevalent types of drugs people seek help for in Northern Ireland (IAD, 2022) and indicate a more diverse range of drugs in comparison to the first NIADA study (Higgins et al., 2020).

Participants could also select multiple options for how they took their main drug/s during the pandemic. Similar to current drug use, most people swallowed their main drug (77%), followed by smoked (30%), snort (12%) and inject (9%).

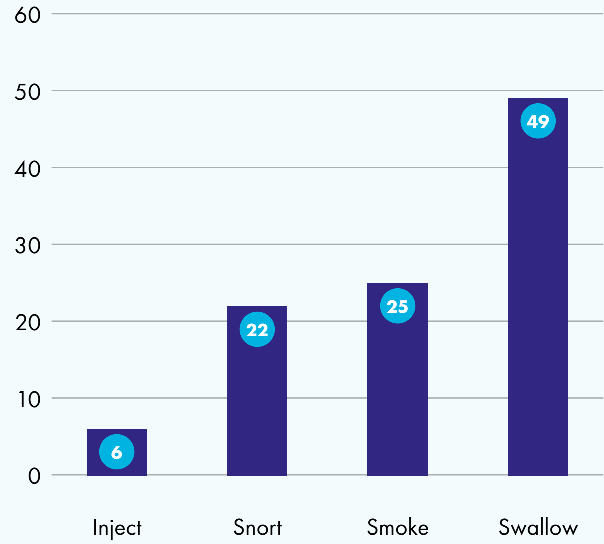
[17]The graph is based on the number of responses and not percentages.
[18]The maximum number of main drugs reported was 7 (1%).

Figure 23: Main Drug Used During Past 4 Weeks



Most participants (78%) reported using their main drug/s during the past four weeks. NIADA clients could select multiple options for how they consumed their main substance. The majority swallowed their main drug (69%), followed by snort (35%), smoke (31%) and inject (8%).

Figure 24: Main Drug Route of Administration During the Past 4 Weeks[19]



5.2.2 Clients Secondary Drug Use

NIADA clients were asked if they had used any other drugs during the COVID-19 pandemic and could select multiple answers. Out of the 92 participants, 24% stated they had used other drugs. This is a lower percentage of people using other drugs in comparison to the first NIADA study (57%) (Higgins et al., 2020). However, the current study allowed participants to select multiple options for their main drug use to reflect the growth of polydrug use in Northern Ireland (DOH, 2021a; Higgins et al., 2020).

Table 3: Secondary Drug Use During Pandemic

Secondary Drug Use	N	%
Cannabis	12	55%
Alcohol	8	36%
Cocaine/crack cocaine	8	36%
Pregabalin	6	27%
Benzodiazepine	5	23%
Codeine*	4	18%
Other Opioids**	4	18%
MDMA	4	18%
Spice***	3	14%
Amphetamine	3	14%
Heroin	2	9%
OST****	2	9%
Meth/Crystal Meth	1	5%
LSD	1	5%

Figure 25: Secondary Drug/s Route of Administration[20]

* E.g., Co-codamol or Nurofen Plus; ** E.g., tramadol, morphine, dihydrocodeine; *** E.g., synthetic cannabinoids; **** E.g., Methadone/Subutex/Suboxone/Buvidal.

[19] The graph is based on the number of responses and not percentages.
[20] The graph is based on the number of responses and not percentages.

Table 3 reports a diverse range of secondary substances (similar to Higgins et al., 2020). Almost two thirds (58%) of these NIADA clients reported using two or more other drugs, while 42% used one other drug which also suggests increased polydrug use and an intensified cohort of clients (DOH, 2021a; Higgins et al., 2020).[21]

Over half reported cannabis (55%) as their secondary drug use during the pandemic. The second most reported drug was alcohol (36%), followed by cocaine/crack cocaine (36%), pregabalin (27%) and benzodiazepines (23%). Similar to main drug use during the pandemic, most swallowed (68%) their secondary drug/s, followed by smoke (59%), snort (41%) and inject (14%).

Figure 26: Secondary Drugs Used During Past 4 Weeks

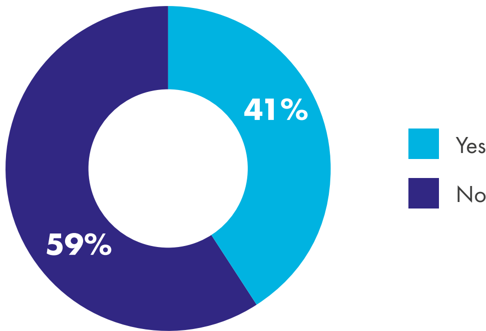
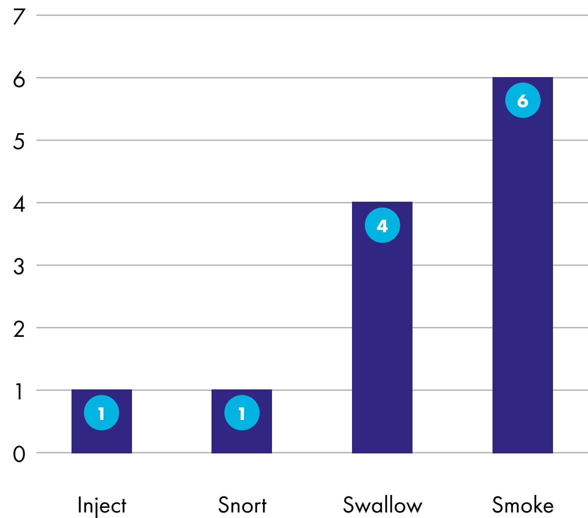


Figure 27: Clients Secondary Drug/s Route of Administration During Past 4 Weeks[22]



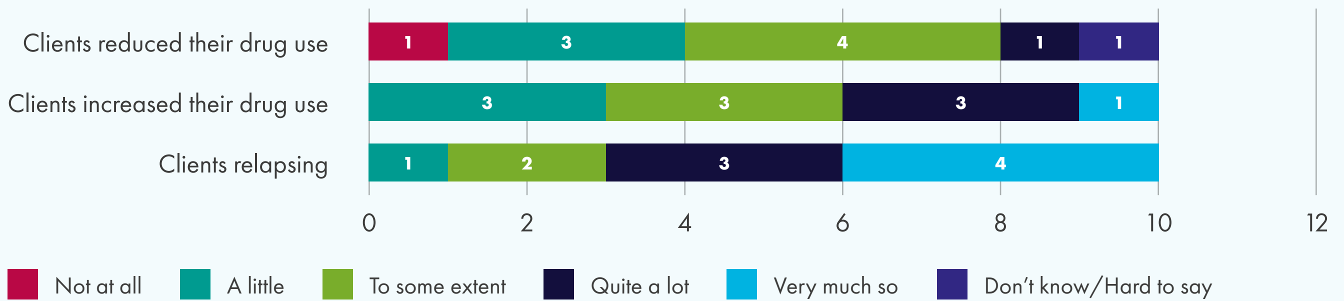
When asked about current other drug use, 41% reported using other drugs during the past four weeks. Participants could select more than one option for how they took their other drugs. Out of the 41% who continued to use other drugs, most smoked (67%), followed by swallow (44%), snort (11%) and inject (11%). Decreased use may be related to infection control measures lessening during fieldwork for the study and increased engagement with support networks including services, families and peers.

[21] The maximum number of main drugs reported was 11 (10%).
[22] The graph is based on the number of responses and not percentages.

5.3 Drug Use Patterns

This section reports on drug use patterns evident during the pandemic from the perspective of providers, clients and family members. The key patterns of decreased or stopped drug use, no change, increased drug use, new drug use behaviours and increased injecting-related harms are discussed.

Figure 28: Service Provider Reports on Drug Use Patterns



NIADA providers were asked to what extent they had observed the above behaviours in their clients during the COVID-19 pandemic. As seen in Figure 28, 70% reported low rates of clients reducing their use, with 10% denoting a high decrease and 10% observed no reduction.

All providers observed increased drug use, with 60% reporting a low increase and 40% observing a high increase. Similarly, all providers reported increased levels of clients relapsing, with 30% noting a low increase and 70% observing a high increase.

Figure 29: Main Drug Use During Pandemic

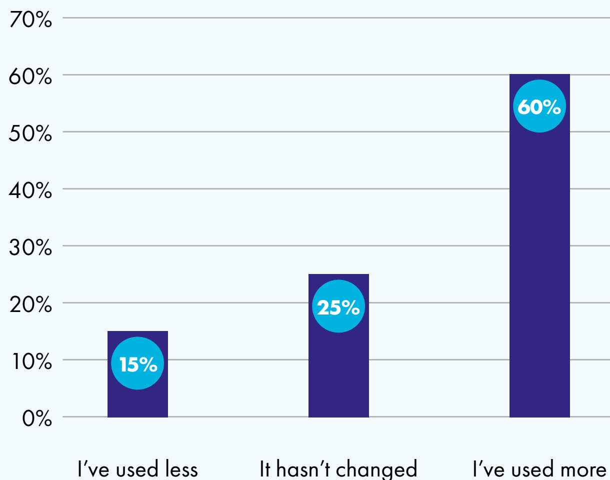
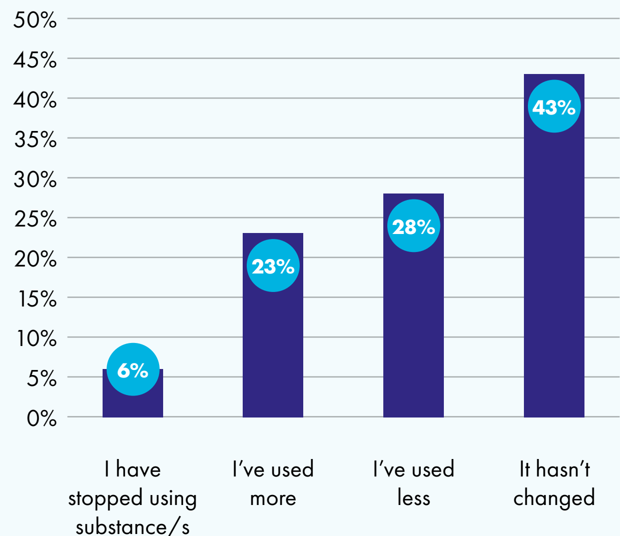


Figure 30: Main Drug Use Past 4 Weeks



The NIADA client survey asked participants about their main drug use patterns during the pandemic and the past four weeks. Figure 29 highlights that two thirds of clients (60%) reported using more of their main substance during the pandemic.

A quarter (25%) reported their drug use had not changed and 15% reported using less. Regarding main drug use over the past four weeks, 43% stated no change, 28% used less, 23% used more and 6% stopped using their main drug.

Figure 31: Clients' Main Drug Use Patterns During the Pandemic By Subgroup[23]

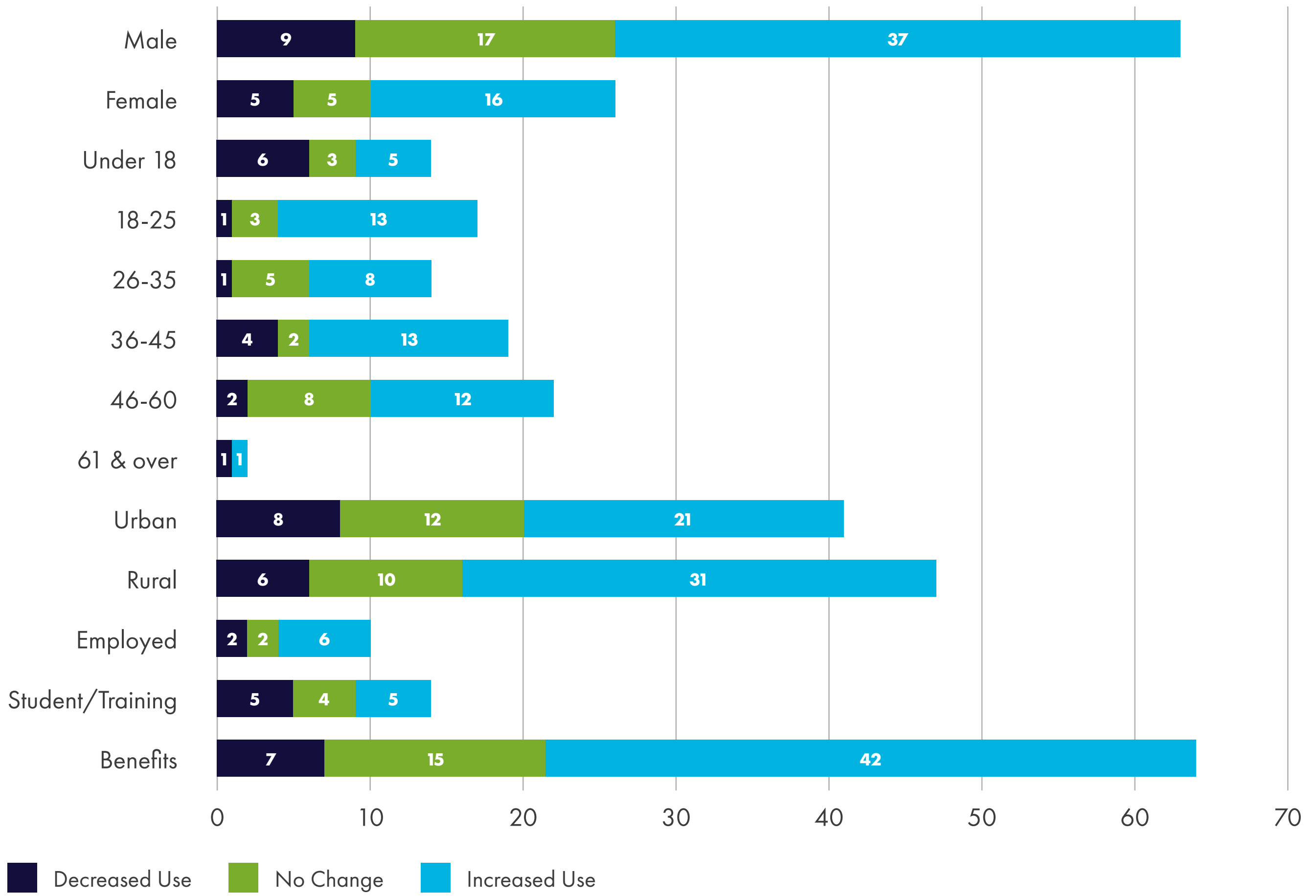


Figure 31 presents NIADA clients main drug use patterns during the pandemic by subgroup. The graph shows that most men and women reported increased use. Most participants aged under 18 years reported decreased drug use, but most people in the other age categories reported increased use. Most people in both urban and rural locations, employed or on benefits used more of their main drug during the pandemic.

[23]The graph is based on the number of responses and not percentages.

Figure 32: Clients' Main Drug Use Patterns During Past 4 Weeks By Subgroup[24]

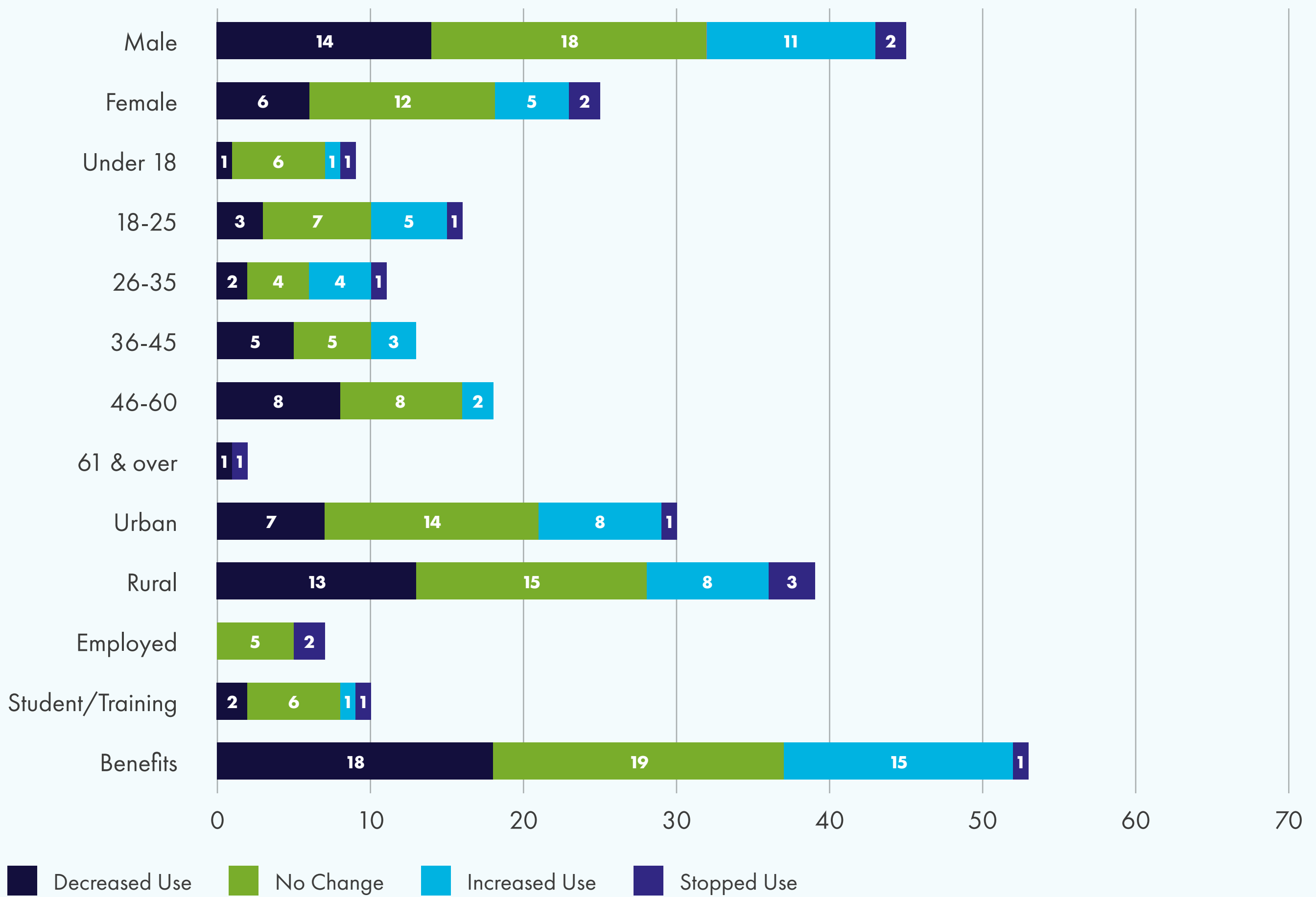


Figure 32 depicts subgroup results for patterns of main drug use over the past four weeks. While the numbers are small, the graph suggests changing drug use patterns in comparison to during the pandemic. The dominant pattern for men and women, and people living in urban or rural location was either decreased or no change to their use. Regarding age groups, people aged 36 to 60 years had respective equal numbers for no change or reduced use. By contrast, the dominant pattern for people aged under 18 years to 25 years was no change. Most people receiving benefits either had no change or reduced use but the number reporting increased use is quite large in comparison to other groups.

There was also a significant link between employment status and drug use patterns over the past four weeks. People on benefits were more likely to report no change to their drug use in comparison to those who were employed and students/in training.

Seventy eight per cent stated their main drug use had changed in some way over the past four weeks. Similar to Higgins et al. (2020), changes were interpreted as either related to reduced use or changing the way they took drugs. Qualitative survey responses stated swapping spirits for beer, smoking heroin in rolled cigarettes rather than foil, and practising more harm reduction techniques.

[24]The graph is based on the number of responses and not percentages.

Figure 33: Secondary Drug Use During Pandemic

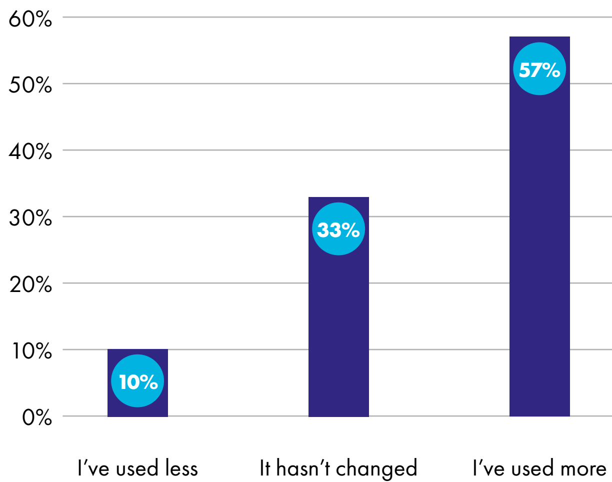
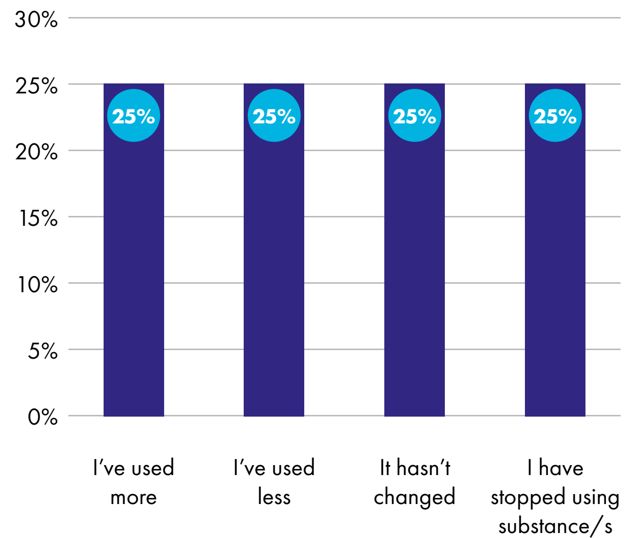


Figure 34: Secondary Drug Use Past 4 Weeks



Regarding secondary drug use, similar patterns to main drug use were discerned. Almost two thirds (57%) reported using more other drugs during the pandemic, just over a third (33%) reported no change and 10% stated using less (see Figure 33).

By contrast, with regard to secondary drug use in the past 4 weeks (Figure 34), there were equal numbers of people reporting using more, less, no changed and stopping use of other drugs in the past four weeks. However, the numbers are very small for secondary drug use and no conclusions can be made about this pattern.

Figure 35: Clients' Secondary Drug Use Patterns During the Pandemic By Subgroup[25]

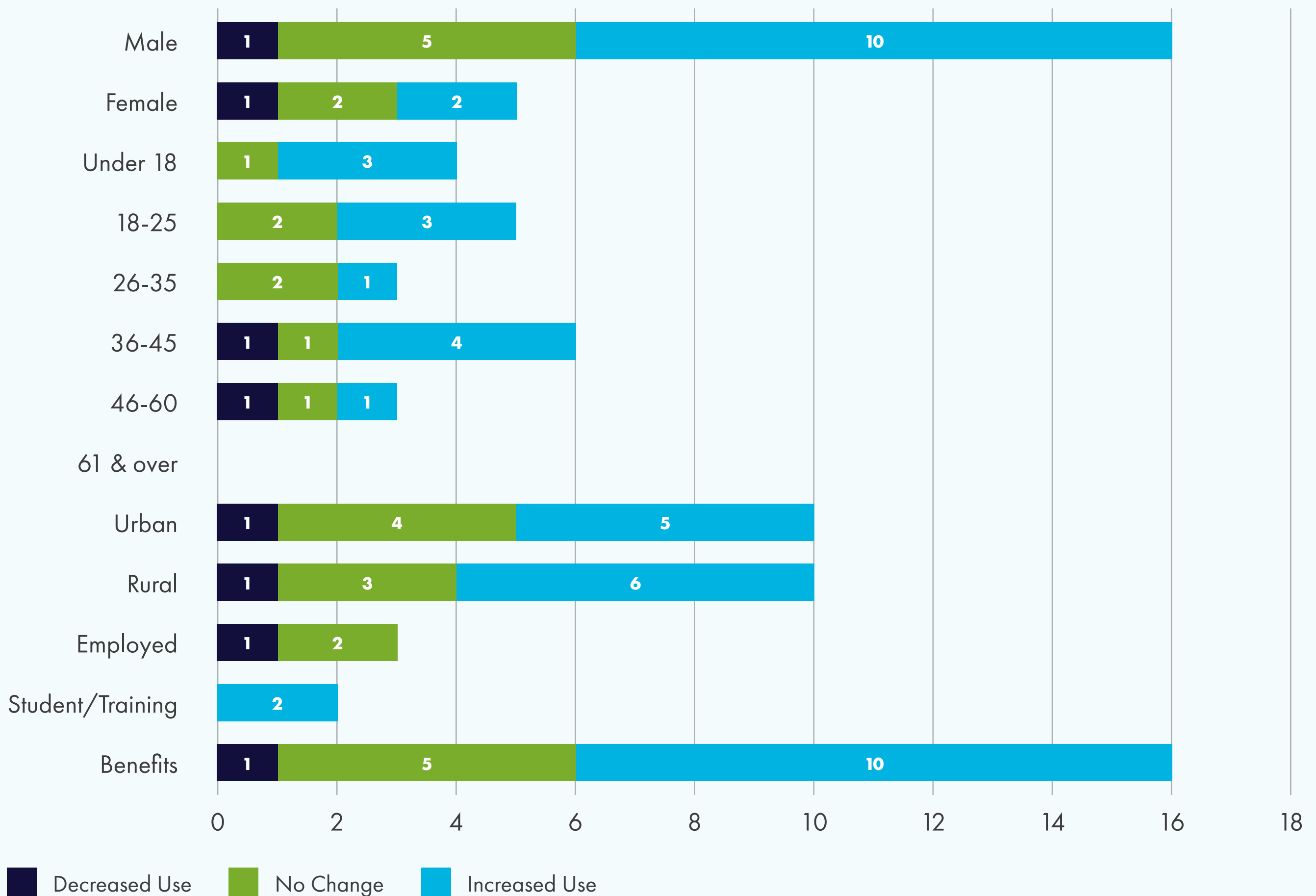


Figure 35 depicts subgroup results for people who used other drugs during the pandemic. Results indicate most men used more secondary drugs during the pandemic, while women had equal numbers of increased use or no change. The dominant pattern for most people aged under 18 years to 25 years and those aged 36 to 45 years, people living in urban and rural locations, students/in training and on benefits was increased use. These findings suggest an intensified cohort of clients using multiple substances.

Findings in this section contrast to the original NIADA study which reported a dominant pattern of people using less of their main and secondary drug/s during the early stages of the pandemic (Higgins et al., 2020). However, it was noted that relapse was becoming more prominent in the later stages of fieldwork for this research. Higgins et al. (2020) suggested that the decreased use they found was a temporary dominant pattern of use. The current study was completed during the end of the third lockdown and the transition out of pandemic restrictions. Current findings are in line with Higgins et al. (2020) suggestion that patterns of use changed as lockdowns continued and with other European findings on consumption patterns following the first lockdown (EMCDDA, 2022, 2021a). Dominant patterns during subsequent lockdowns were increased or normal levels of substance use at pre-pandemic levels dependent on the drug and country.

5.3.1 Decreased or Stopped Use[26]

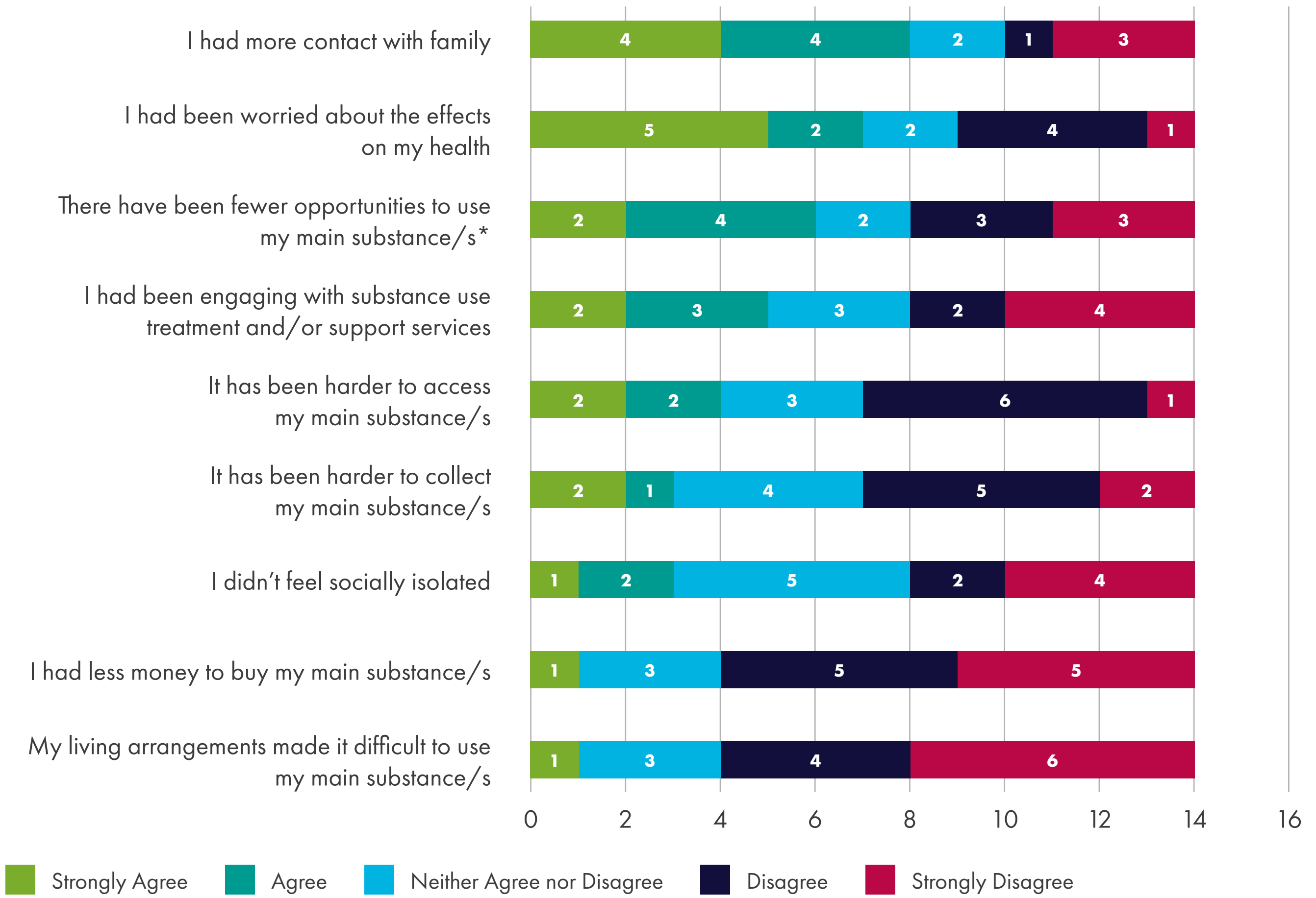
Survey and qualitative results suggested decreased drug use was the least dominant drug use pattern during the pandemic, while usage during the four weeks prior to survey participation suggested reduced or stopping main drug use were becoming more prevalent for some people.

In the client survey, participants were asked how much they agreed/disagreed with the below reasons for reducing their main substance use during the pandemic and in the past four weeks.

[25] The graph is based on the number of responses and not percentages.

[26] Results in Section 5.3.1-5 focus primarily on reasons for main drug use patterns as the numbers for secondary drug use in the NIADA client survey were too small to indicate patterns.

Figure 36: Clients' Reasons for Decreased Main Drug Use During the Pandemic[27]



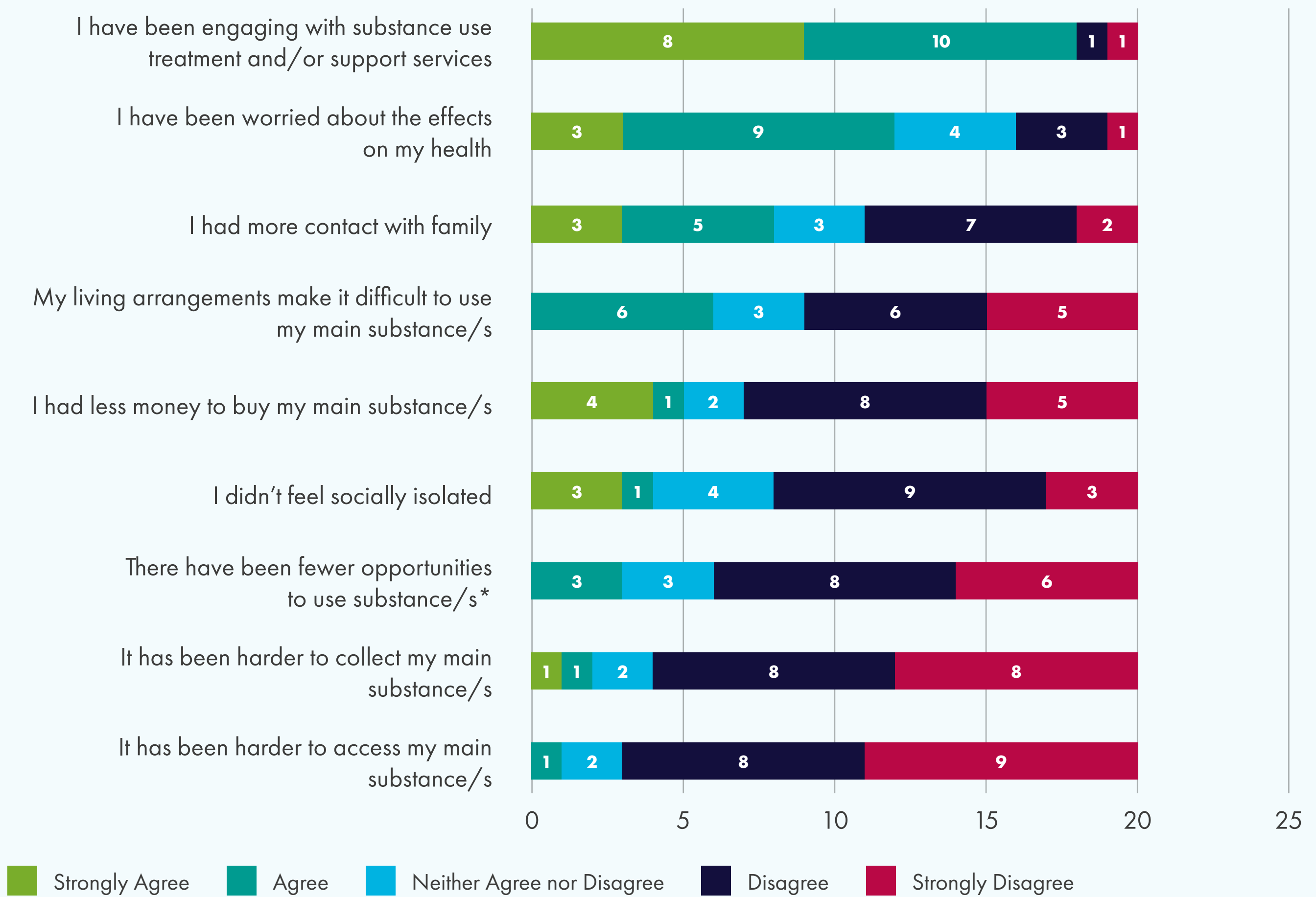
*Due to closure of clubs/bars, restrictions on meeting up with friends.

Figure 36 highlights that the strongest reason for reduced use during the pandemic was having more contact with family with 57% agreeing/strongly agreeing.

The second most prevalent reason was concerns for health (50%), followed by having fewer opportunities to use drugs given closures of clubs/bars and restrictions on meeting with friends due to the pandemic (43%).

[27]The graph is based on the number of responses and not percentages.

Figure 37: Clients Reasons for Decreased Main Drug Use During Past Four Weeks[28]



*E.g., meeting up friends.

Figure 37 shows that the majority (90%) reported the strongest reason for reducing drug use in the past four weeks was engagement with substance use treatment and/or support services. Similar to main drug use during the pandemic, two thirds (60%) reported concerns about health as the second most common reason for reduced use. The third reason was having more contact with family (40%).

The findings clearly highlight the important role of family support in tackling substance use and suggest pandemic restrictions did reduce substance use for some people. Concerns about health also feature strongly as a reason to reduce use for some people. The prominence of engagement with substance use services in results for current use is likely connected statutory drug treatment services becoming fully operational during this period and NIADA services returning to some forms of face-to-face delivery.

Qualitative findings also indicated that decreased use was the least dominant drug use pattern during the pandemic affecting a minority of NIADA clients. Some providers working with the homeless community stated that certain clients had reduced use during the first lockdown (also reported by Higgins et al., 2020). Decreased use was linked with reduced movement, access to certain drugs, social support among peers and motivations to reduce or stop use.

> *It's interesting that some of our more 'chaotic' clients, and I don't like using that phrase, but you know by which I mean, that their lives are very different from day to day but the common thread may be a combination of alcohol and substance use and over decades sometimes. They actually bunkered down, they actually settled down, they became very supportive of one another, in many instances their substance and alcohol use reduced. There were spikes at times, and that's to be expected, but among that more traditionally challenging group, they actually became more settled and more supportive of one another.*
>
> **De Paul**

[28]The graph is based on the number of responses and not percentages.

I used less as availability had lessened but also I had been working towards stopping my heroin use.

16, Male Client, early 40s

Providers and some clients believed that infection control measures during the first and subsequent lockdowns had prevented meeting up with friends and peers reducing the setting, pressure and opportunity to use drugs for some people. Similar to Seddon et al.'s (2020) research on alcohol use among older people in the UK, closure and restricted opening hours for licensed alcohol premises were cited as reasons for reduced or stopping alcohol use.

Some people report, because they haven't met their friends and the sort of crowds they used to hang about with, they're drinking less.

ASCERT Adult Services

So when all [licensed pubs and restaurants] shut down, some of our service users actually expressed that they felt a bit safer because they weren't necessarily the sort of person in addiction who would have gone out to the supermarket, who would have purchased the alcohol or whatever. They were more the person who went to the pub, and so therefore whenever all that shut down, they felt safer.

Davina's Ark

For other clients during subsequent lockdowns, reduced use or abstinence was linked to good family and social support, levels of resilience, motivations to reduce or stop use, engagement with treatment and support services, mental and physical health particularly for older clients.

Got to a stage [due to physical illness] where I just physically couldn't do it [substance use]. I physically couldn't do it. I just I couldn't [...] You were probably expecting me to come on, 'Alright it did this, it drove me to that, that bleeding pandemic.' It had the adverse effect on me, it got me off [drugs]. Well it didn't get me off, it gave me the time I needed and the space I needed to get off it.

12, Male Client, mid 50s

About five weeks [after the pandemic started], my body shut down and I developed this thing called [medical condition] [...] And that's the strangest thing to say, in that it [COVID-19] allowed me time to recover quietly and peacefully. I would say that just it allowed me to recover and not put me under pressure about having to go to work. So COVID for me was, it's so ironic and strange to say it, but COVID for me, was a reasonably nice breath of fresh air. 1

01, Male Client, mid 50s

Continued restrictions provided opportunities for reflection and change for some clients. Increased engagement with services, including becoming engaged or reengaged with statutory substance use services, and restoration of family and support structures was emphasised.

Well, I started on [OST] during the pandemic and it's going well, just about perfectly [...] The heroin use has been eliminated.

16, Male Client, early 40s

At present I am strongly engaging in addiction services. I have been off [drugs] for maybe five or six weeks. Recently enrolled in local CAT [Community Addiction Team]. Prior to this, I didn't give a damn, now I am trying to kick it.

Male Survey Participant, early 60s

There was a small minority of the clients that completely abstained, completely, and they stopped using, they reflected on their life and they said 'You know what, I'm worth more than this. I'm not doing this anymore' [...] And they've actually really tried to really think about things, and some of them have actually now got wee flats of their own and are really trying to get back into life and trying to get a job.

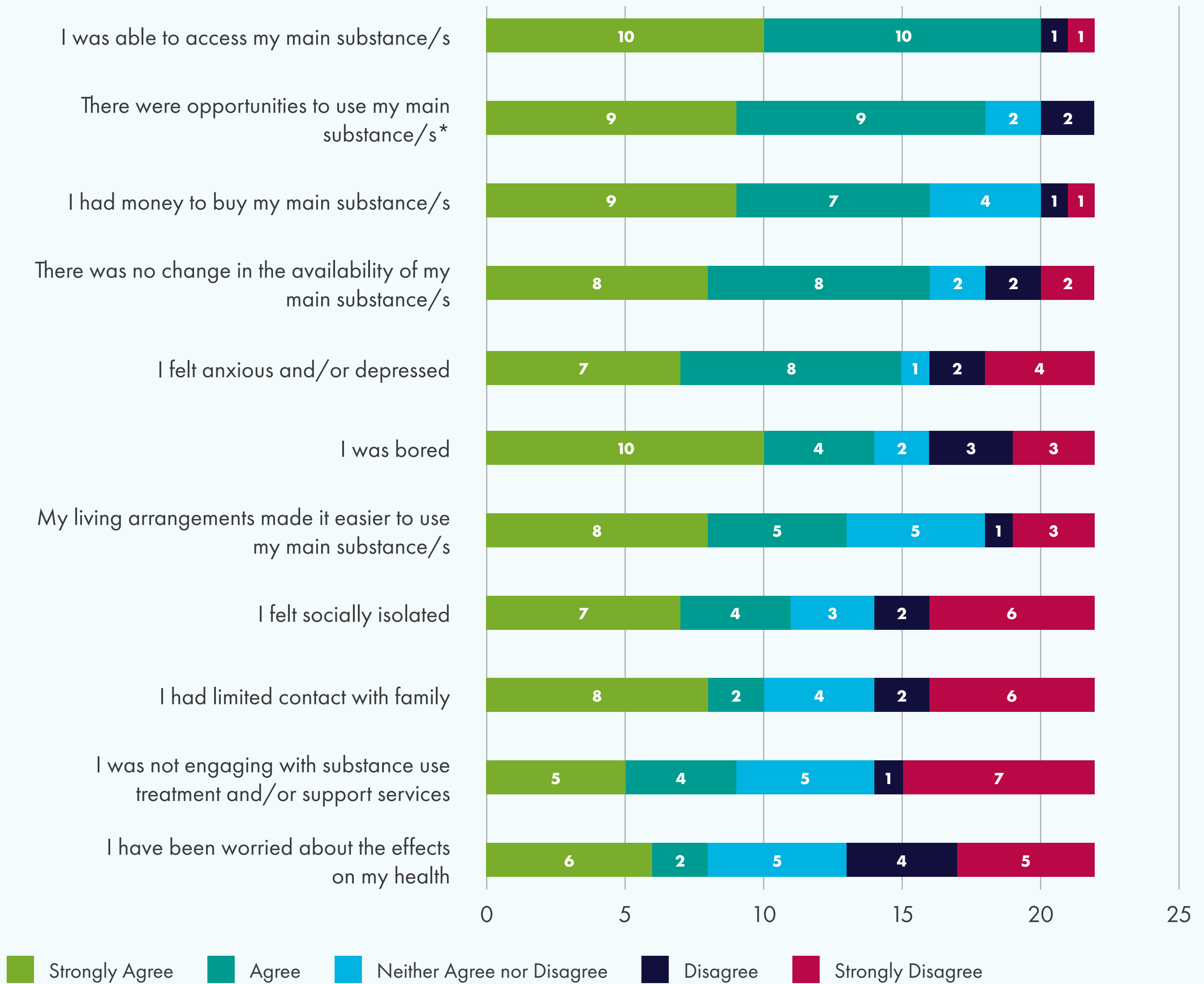
ASCERT Youth Services

5.3.2 No Change

While the survey did not contain a specific item on whether providers had observed no change to their clients' drug use, qualitative data and the NIADA client survey discerned that was the second most prevalent drug use pattern during the pandemic and the most dominant pattern for current use.

In the client survey, people were asked how much they agreed/disagreed with the the reasons stated in Figure 38 for no change to their substance use during the pandemic and in the past four weeks.

Figure 38: Clients' Reasons for No Change to Main Drug Use During the Pandemic[29]

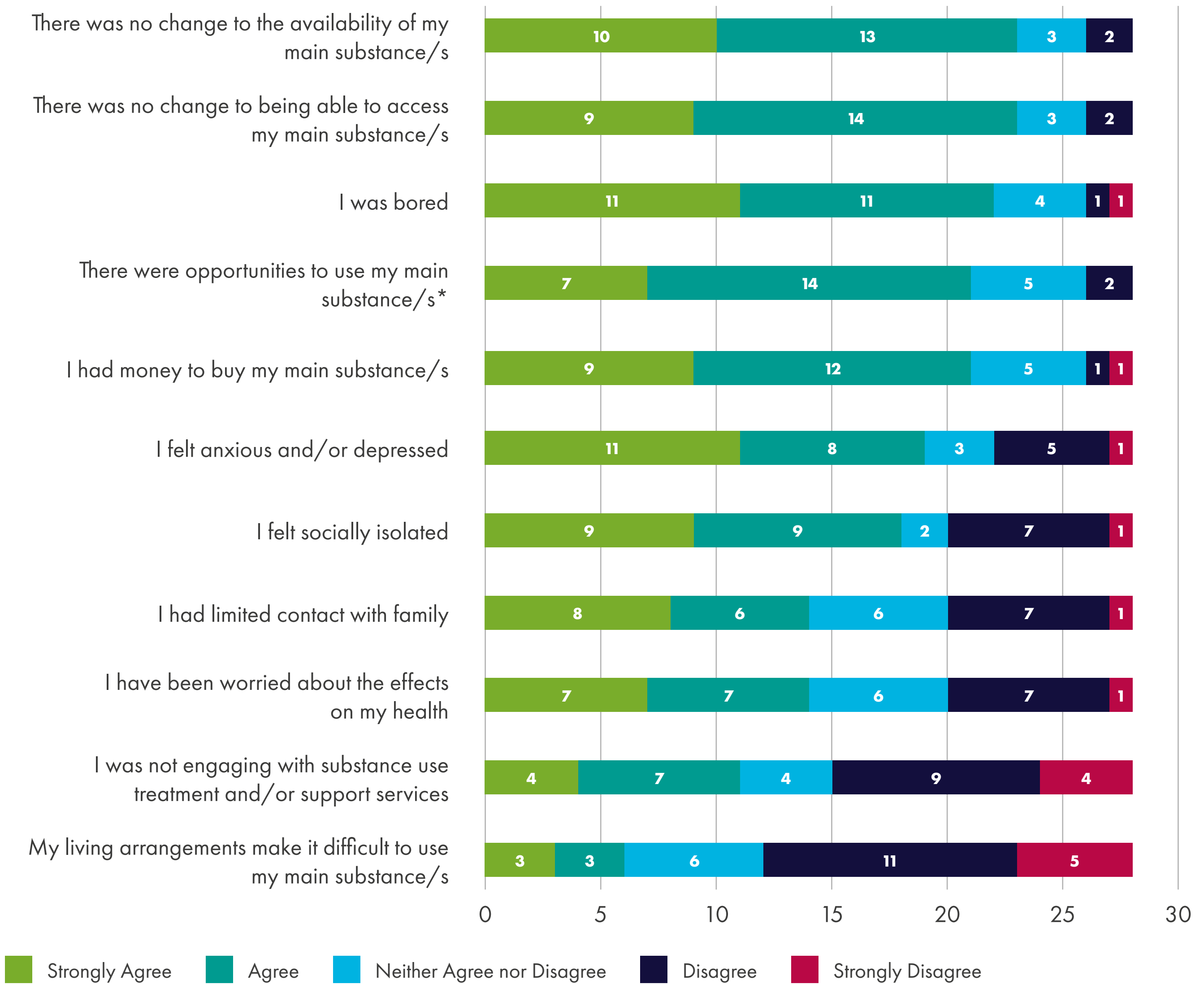


*E.g., not working, being with friends.

Figure 38 shows that... The strongest rationale for no change to main drug use during the pandemic was being able to access drugs, with 90% agreeing/strongly agreeing. The second reason was opportunities for using main drugs (81%) due to working or continuing to meet with friends despite pandemic restrictions. Continuing to have money to buy main drugs (81%) was the third most popular reason.

[29]The graph is based on the number of responses and not percentages.

Figure 39: Clients' Reasons for No Change to Drug Use During the Past Four Weeks[30]



*E.g., not working, being with friends.

Regarding no change to main drug use over the past four weeks, the main reason was no change to the availability of main drugs (82%), followed by being able to access main drugs (82%). The third reason for no change was being bored (78%).

Continued access to drugs is likely due to most participants using alcohol as their main drug and this continued to be accessible with restrictions throughout lockdown periods. However, results can also be linked to the relative stability of illegal drug markets during the pandemic and in the four weeks prior to survey participation.[31]

These explanations interconnect with the dominant responses to the past four weeks where availability and access were the strongest reasons for no change. Findings during the pandemic suggested that some people continued to meet with friends or peers despite lockdown restrictions and that some were not adversely affected by financial pressures. Boredom contributing to no change to drug use over the past four weeks indicates a need for more diversionary activities to combat this factor.

[30]The graph is based on the number of responses and not percentages.
[31]See Section 5.1.

Qualitative findings also identified no change to drug use as the second most prevalent drug use pattern during the pandemic although there were some variations. No change to drug use was explained in two main ways; continued drug use and maintenance of recovery.

Regarding maintenance of recovery, providers and some clients noted that people in longer term recovery with strong social support and engagement with remote substance use services remained abstinent and avoided relapse. However, one client noted that pandemic restrictions made maintaining abstinence difficult at times due to adverse health and social impacts[32] previously discussed.

> *I'm now sober [number of] years past. And I have made major big steps. I feel lockdown has probably hindered some of it but I had made steps regardless, smaller maybe during lockdown than what maybe they could have been.*
>
> 15, Female Client, mid 40s

> *We expected an awful lot of our service users to relapse as a result of the lockdown, a far greater number than who actually did. Our numbers seemed to stay quite steady throughout the course of lockdown.*
>
> Davina's Ark

> *For a lot of us [service users] it was like a validation, 'No, we can do this [remain abstinent]. My goodness, I've just lived through a pandemic sober and I didn't even have a drink.' There was that feeling and there was nearly like an excitement with that.*
>
> Regional Service User Network

> *Gray's Court is supported living accommodation [...] and nobody in that relapsed over the whole year and a half, and that's quite unique that's never happened before. They became a really strong group. But then it was more the people that didn't have a group or didn't have contacts or were on their own and felt alone that maybe was struggling more.*
>
> Carlisle House and Gray's Court

Similar to survey results, other providers, clients and family members noted that drug use remained relatively stable for some client groups given continued access to alcohol and other drugs. If preferred drugs were not available, some people substituted with other drugs. Despite pandemic restrictions, people continued to meet with friends and peers providing the opportunity to source and use drugs.

> *I don't think [adult child] or any of [their] friends, really have taken any of the precautions with COVID. You know, avoiding each other, staying out of each other's houses, the drugs still readily available. There's no issue with that, so it has had absolutely no impact on their life.*
>
> 03, Family Member

> *COVID hasn't really changed my drug use, it would be a perfect excuse to say it has but it hasn't. I am just taking the drugs to not feel sick. And I was still able to access drugs.*
>
> 06, Female Client, mid 40s

> *There was really very little change for some. They found the means to get what they needed and they kept themselves kind of at the level that they were, because we did try and track those changes.*
>
> Simon Community

Some clients also related continued drug use with experiencing high levels of adverse health and social impacts[33] associated with the pandemic. Lengthy waiting times and constrained access to statutory substance use services before and during the pandemic was also emphasised.

> *To be honest with you, nothing [substance use] really changed for me [during the pandemic], just remained the same [...] Hard to get an appointment [with statutory substance use treatment services] nowadays, the waiting lists, there's not enough really, not enough, there could be a lot more in place. A lot more detox places, less waiting time.*
>
> 13, Male Client, early 50s

[32] See Section 4.
[33] See Section 4.

5.3.3 Increased Use

Increased drug use during the pandemic was the most prominent drug use pattern in both survey and qualitative data. However, using more drugs dropped in importance when considering consumption during the four weeks prior to client survey participation.

In the NIADA provider survey, practitioners were asked the extent to which they had observed the below changes to specific types of substance use among their clients given initial research in Northern Ireland suggesting increased use (Higgins et al., 2020; Campbell et al., 2021).

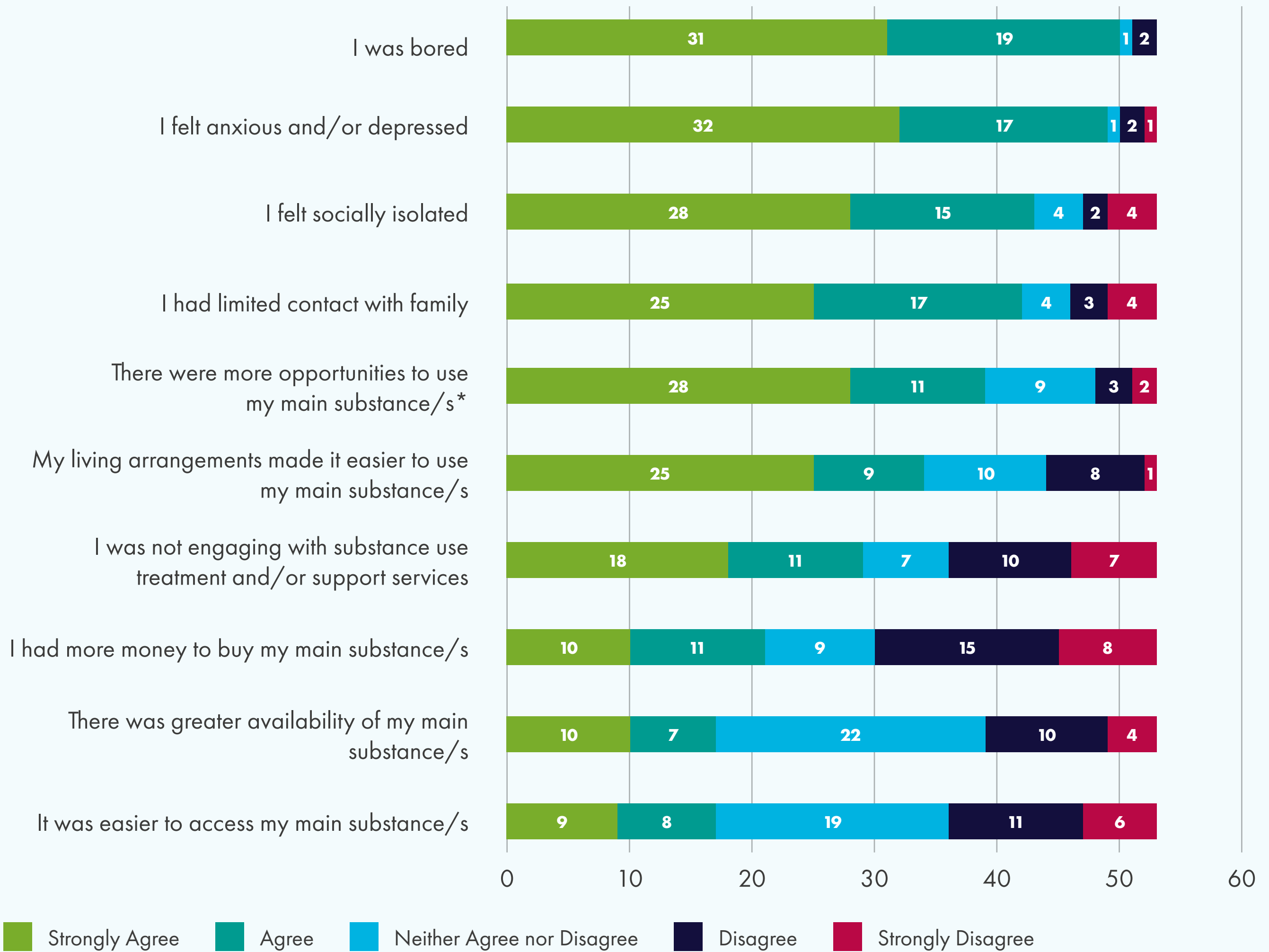
Figure 40: Service Provider Reports on Increased Use for Specific Drugs

Figure 40 illustrates that increased alcohol use was the most prevalent change observed - 80% noted a high increase and 20% a low increase. Increased counterfeit benzodiazepine use was the next most prevalent change with 70% observing a high increase in this. Elevated cocaine use was observed by all organisations. A large increase of over-the-counter prescription drug[34] use was identified by 50%, with 40% observing a low increase. Lastly, a large increase in benzodiazepine use was identified by 40%, with 60% observing a lower increase.

In the NIADA client survey, participants were asked how much they agreed/disagreed with the below reasons for increased main drug use during the pandemic and in the past four weeks.

[34]Refers to codeine based over the counter prescription drugs e.g., Co-codamol and Nurofen Plus.

Figure 41: Clients' Reasons for Increased Main Drug Use During the Pandemic[35]

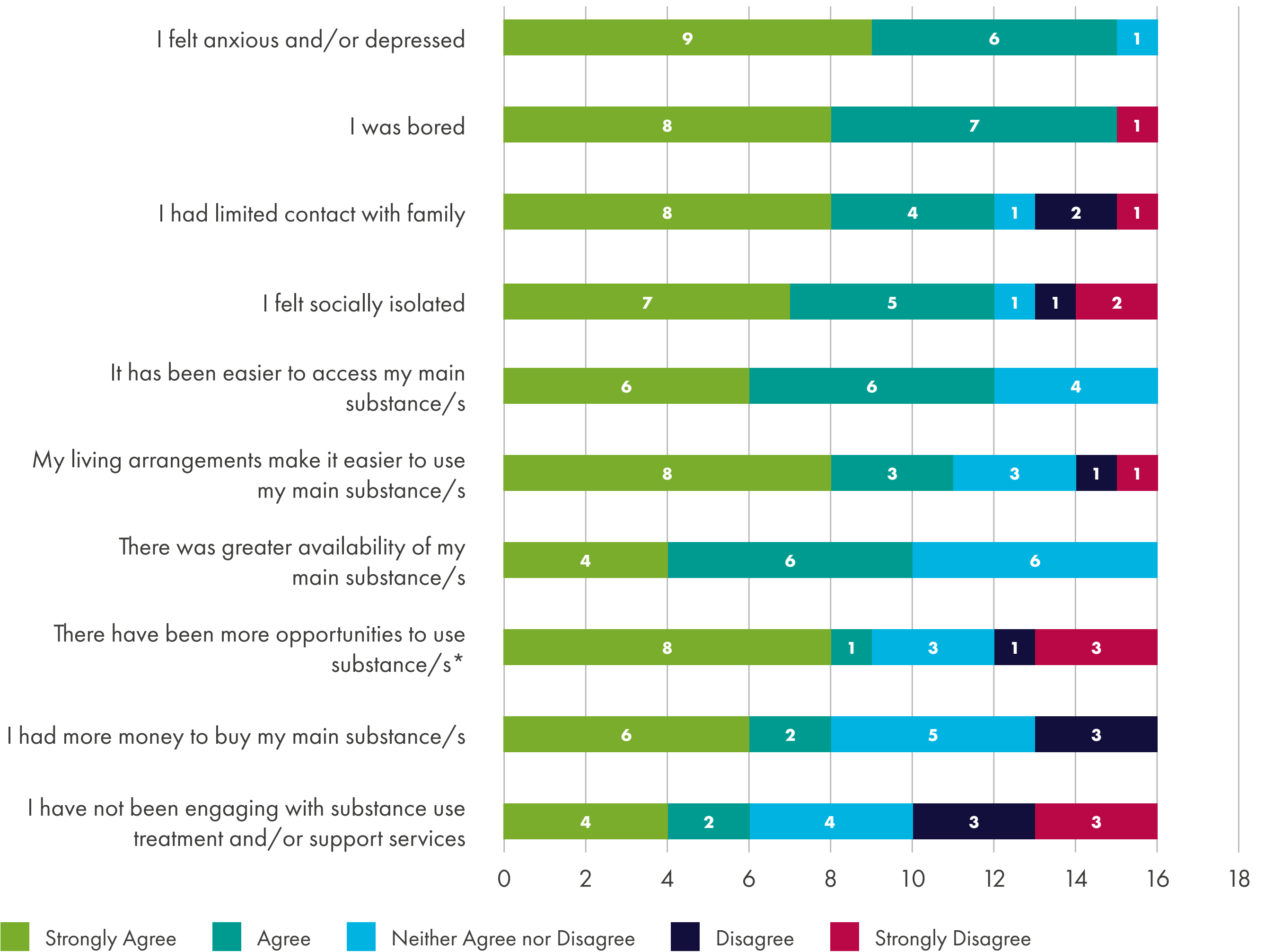


*E.g., not working, being with friends.

Figure 41 highlights that the strongest reason for increased use during the pandemic was being bored with 94% agreeing/strongly agreeing. Feeling anxious or depressed was the second most prevalent response (92%), followed by feelings of social isolation (81%).

[35]The graph is based on the number of responses and not percentages.

Figure 42: Clients Reasons for Increased Main Drug Use During Past Four Weeks[36]



*E.g., opening of clubs/bars, less restrictions on meeting up with friends.

Regarding main drug use during the past four weeks, Figure 42 shows that feeling anxious and/or depressed was the strongest reason for increased use (94% agree/strongly agree). Being bored was the second most prevalent reason (94%), followed by having limited contact with family (80%).

The impact of the pandemic on boredom is emphasised in both sets of findings for increased use and likely linked to pandemic restrictions, isolation and lack of engagement in diversionary activities. Other research suggests links with the adverse and continued impacts of COVID-19 on mental health[37] and subsequent elevated levels of anxiety and depression combined with difficulty dealing with social isolation (EMCDDA, 2022, 2021a; Foster et al., 2021; Seddon et al., 2022). The substantial impact of limited family contact on current increased use indicates the important role of family support in combatting drug use and continued social distance from families and/or family conflict despite social distancing requirements lessening.

[36]The graph is based on the number of responses and not percentages.
[37]See Section 4.2.

Qualitative data found that elevated levels of use during the pandemic was also linked to continued accessibility and availability of alcohol and other drugs.[38] Increased use or relapse was also predominantly experienced by people most affected by adverse health and social impacts.[39] These clients tended to have weak social support networks, poor engagement with services and experienced heightened levels of social isolation contributing towards increased use or relapse.

> *Social isolation has been a major trigger to increased substance use.*
>
> **Regional Service User Network**

> *Some of our service users did relapse [...] They tended to be those sort of service users though who were isolated, who lived on their own. Because the pandemic, when it hit, it was so sudden and brought up an awful lot for people as well. So particularly those who live on their own, who are isolated, they have so much more time on their hands to sit and to think, for memories and so on, experiences etc, to come up to the surface.*
>
> **Davina's Ark**

Restricted access to substance use services and/or the technology to engage in remote delivery of services[40] were also related to higher levels of use. This was a dominant issue for some older people, those living in remote rural locations and the homeless community. The increased transient nature of the homeless community was particularly emphasised due to impacts on support networks and/or inaccessibility of statutory substance use services which had been temporarily suspended and continued to have lengthy waiting lists.

> *Felt under increased pressure due to being on remand and living in a hostel far from family and friends.*
>
> **Male Survey Participant, early 20s**

> *There was some plans in the future that [adult child] would be able to get in to do detox and then into rehab. The problem is that there's so few places for these, there's big long waiting lists and because [adult child] has this nomadic life. [Adult child] literally moves about so much, and the difficulty for that is how do you access services when you move so much?*
>
> **02, Family Member**

For young people, boredom appeared to be a key driver behind increased use given the move to remote schooling and reductions in face-to-face services impacting social support networks and diversionary activities.

> *Because of, like, how boring it gets [due to pandemic restrictions], but I can see all my mates, but it has had an impact, because they all started doing like other stuff like MDMA and all. But I wouldn't be doing any of that, and then just, I guess, because there was nothing really to be doing besides going out and drinking and smoking.*
>
> **02, Male Client, teenager**

> *As soon as COVID hit and all the restrictions got put in place and [child] couldn't go anywhere and [child] couldn't get out with [child] friends, it did have a big impact on [child] [...] They've been drinking more since COVID had kicked in, taking drink from the cupboards in the house, being sneaky, smoking weed in the house. [Child] never smoked weed before.*
>
> **01, Family Member**

> *I was not at school so was using all day and night and not coming home for days and going missing.*
>
> **Male Survey Participant, teenager**

Increased alcohol consumption appeared most prevalent among older (aged 45 years plus), more socially isolated clients in rural areas. However, providers also reported increasing numbers of clients aged 30 to 44 years, who were typically furloughed or working from home or had become unemployed, presenting for help with problematic alcohol use.

> *I think for us, the biggest increase we saw was in those older clients who felt the most isolated and who felt they had the least capacity to make a change. And we've seen some really significant increases in alcohol and substance abuse in the over-45s and even like in the over-55s and 60s, like that was really sad, seeing people going into very poor condition very quickly [...] And even individuals who would have traditionally been seen as not really having a particularly significant challenge there when it comes to substances or alcohol, actually increasing, and all them cited isolation and lack of access to services as being key drivers behind that. And some of it's gone up significantly, with one or two deaths as a consequence, accidental, you know, in some instances people who had very complex health, who just couldn't cope with that additional use and others, one or two where it was accidental overdose.*
>
> **De Paul**

[38] See Section 5.1.
[39] See Section 4.
[40] See Section 6.3.4.

Furlough has led to job loss. Increased alcohol consumption when furloughed, now increased further due to job loss [...] Working from home client started drinking alcohol when working, he feels he can function while using alcohol and working.

Simon Community

Providers and clients also noted temporary inaccessibility of preferred drugs, combined with financial pressures due to social distancing requirements, had increased alcohol use in some settings as illustrated by this participant:

Sometimes I could not get heroin because I could not get enough money, so I got alcohol.

Male Survey Participant, late 30s

Journal entries stated the reopening and lifting of restrictions on licensed alcohol premises had increased use for some clients. The point was made that some people now preferred consuming alcohol at home as it was cheaper but it potentially increased harm due to the risk of higher quantities being consumed.

While increased alcohol use was more prevalent for older client groups, practitioners providing services to young people and family members also reported elevated levels during the pandemic reflected in increased referrals. Increased use was attributed to boredom, fluctuating access to preferred drugs, adverse health and social impacts[41] of the pandemic and some groups of young people continued to meet socially irrespective of COVID-19 restrictions. Journal entries noted that the lifting of restrictions increased social gatherings and peer pressure to engage in alcohol use within certain group settings.

A lot of young people would have drank more, it's an accessible drug [...] young people were meeting up in parks, drinking a lot more like that was a big, massive one, alcohol, the rise in alcohol.

ASCERT Youth Services

Young people who did not get to socialise [during COVID-19 lockdowns] now drinking a lot when getting together in big groups, peer pressure.

Start 360

There was also a tendency for younger client groups to consume strong alcohol drinks which increased harms.

And we're now actually starting to see it within younger clients that are coming through the service who are then going out and drinking, drinking [...] Dragon Soup being one of them, that would be a common alcohol intake for young people and it is 4.3 units per can, stronger than a tin of beer or a vodka, like vodka's 1.3 units, it's like triple that, which is really frightening.

ASCERT Youth Services

As previously discussed,[42] providers highlighted the stability of the cocaine market during the pandemic evidenced through reduced cost and increased availability. Temporary inaccessibility of preferred drugs was also linked to increased cocaine use during the pandemic. Some providers noted more people injecting heroin within specific geographic locations in Northern Ireland substituting or supplementing heroin with stimulants for the aforementioned reasons.[43]

Qualitative interviews and survey responses from NIADA clients also provided insight into other life events and stressors whose impact was intensified as opposed to being uniquely created by the pandemic resulting in increased use or relapse. These included relationship breakdowns, drug debts, bereavement, court cases and work-related stress.

I was getting Ketamine to sell to pay my debts but I used it myself.

Male Survey Participant, late teens

I became heavily dependent on codeine during the pandemic [...] I wasn't using them for pain management, I was using them to try to reduce the stress I was feeling at work.

19, Female Client, early 40s

My [parent] passed away and I had court proceedings regarding [abuse case] lingering in background so all other plans and dreams were put on hold. So, I relapsed for a while.

04, Male Client, early 50s

[41]See Section 4.
[42]See Section 5.1.
[43]See Section 5.3.4 and 5.3.5.

5.3.4 New Drug Use Behaviours

Survey and qualitative data indicated that new drug use behaviours had emerged during the pandemic. Service providers were asked to indicate the extent to which they had observed the below drug use behaviours since the beginning of the COVID-19 pandemic.

Figure 43: Service Providers Reports on New Drug and Risk-Taking Practices

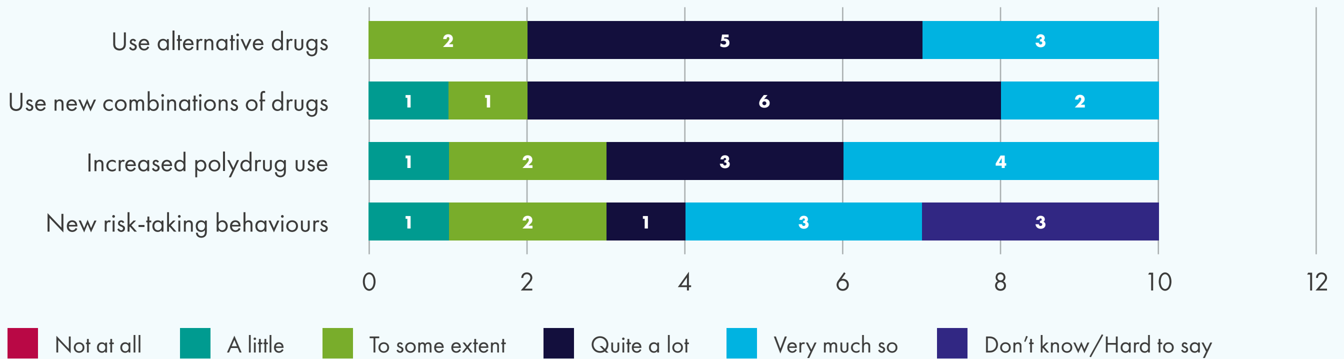
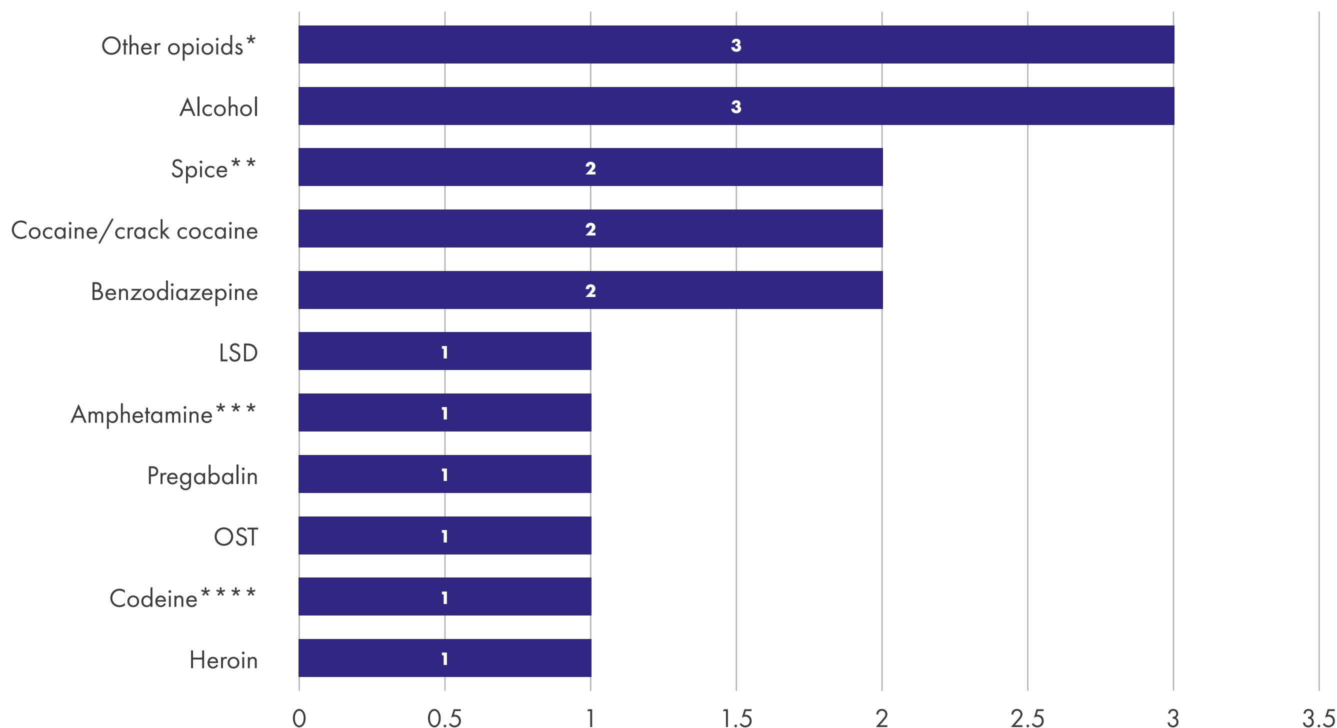


Figure 43 reports that all organisations observed clients using alternative drugs during the pandemic, with 20% noting a low increase and 80% reported a large increase. Similarly, all providers observed a rise in clients using new combinations of drugs, with 20% reporting a low increase and 80% a high increase. Levels of polydrug use increased during the pandemic, with 30% observing a low increase and 70% a high increase.

The graph highlights that 30% observed a low increase in new risk-taking behaviours, with 30% reporting a high increase and 30% did not know. Variations are attributable to the type of services offered and the client group catered for during the pandemic with recovery orientated services being less likely to observe new risk behaviours.

Very few participants (11%) had tried new or different types of drugs during the pandemic.

Figure 44: New or Different Drugs Clients Used During the Pandemic[44]



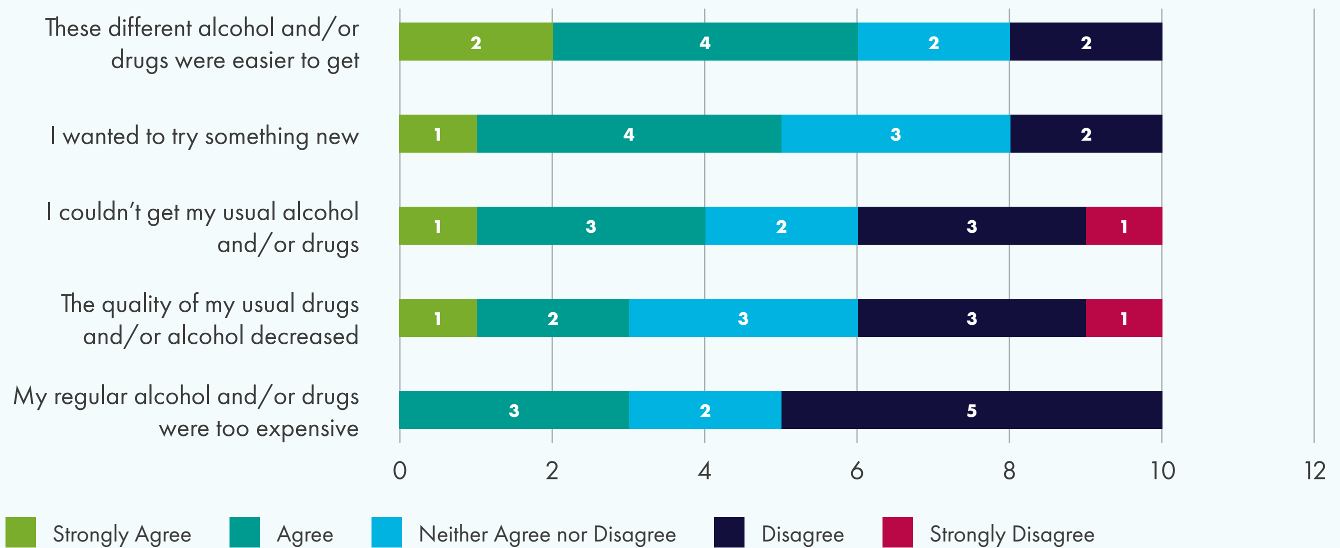
* E.g., tramadol, morphine, dihydrocodeine; ** E.g., synthetic cannabinoids; ***E.g., speed;
****E.g., Co-Codamol or Nurofen Plus.

Participants could select multiple responses for new or different drugs they had used during the pandemic. While numbers are very small, Figure 44 shows that other opioids and alcohol were the most common new or different drugs consumed. The second most frequent responses were spice, crack cocaine and benzodiazepines.

In addition, 11% of NIADA clients stated their main substance had changed to a different drug during the pandemic. Qualitative survey responses detailed their main drug use had changed to one of the following: alcohol (spirits or beer); OxyContin; ketamine; pregabalin; cannabis; prescription drugs; OST; and cocaine/crack cocaine.

[44]The graph is based on the number of responses and not percentages.

Figure 45: Clients' Reasons for Trying New or Different Types of Drugs During the Pandemic[45]



Numbers are small and no conclusions can be drawn, but when asked about reasons for trying new or different types of drugs during the pandemic, the most common response highlighted in Figure 45 was that the new or different drugs were easier to get with 60% agreeing/strongly agreeing. The second most prominent reason was wanting to try something new (50%), followed by difficulty accessing usual drugs (40%), decreased quality of usual drugs (30%) and that regular drugs were too expensive (30%).

As previously discussed in Section 5.1, qualitative data linked new drug use patterns with changes in local drug markets, including temporary inaccessibility and drops in quality and quantities of preferred drugs predominantly during pandemic.

> *Now, at the beginning of lockdown there were issues around, for example, accessibility of cannabis and other drugs. And so what happened is we noticed people mixing and matching more, turning more to prescribed medication, not necessarily even their own, maybe somebody else's in the family.*
>
> ASCERT Adult Services

> *I was using more cocaine and prescription drugs like pregabalin instead of grass [herbal cannabis] as grass was hard to get and sometimes was substituted for spice.*
>
> Male Survey Participant, teenager

> *Far less heroin in a bag, [opioid tablets] were easier to access.*
>
> Male Survey Participant, mid 20s

Shortages of preferred substances led to some clients being 'more willing to try new substances regardless of source' (Simon Community) or using 'unknown substances' (Addiction NI). One organisation (Regional Service User Network) also noted 'a big increase in codeine'-based over-the-counter prescription drugs due to cannabis shortages in the early stages of the pandemic. Another provider observed increased counterfeit and prescription benzodiazepines use among people with alcohol dependency due to lockdown restrictions.

Organisations working with young people cited increases in LSD, synthetic cannabinoids[46], vaping unknown substances and mixing high strength alcohol drinks with high strength caffeine products which increased potential for drug-related harm. While providers noted these patterns emerging prior to the pandemic, consumption rose during the pandemic.

> *Now LSD has come back onto the market, now we had being seeing wee pockets of that before the pandemic hit; however, LSD is back on the market. The feedback we're getting is, 'It's cheaper than cocaine', 'You really get a really good high from it', 'It gives you a good feeling, a nice warm feeling.' So that is one of the drugs which seems to be creeping its way back in [...] Taking spice is another one, now I'm not going to say it's being used province-wide, but there are pockets in all Trust areas where they're using it.*
>
> ASCERT Youth Services

> *Vaping a mixture of substances some of which are unknown to the user. Mixing alcohol with high caffeine, high alcohol drinks.*
>
> Start 360

[45] The graph is based on the number of responses and not percentages.
[46] E.g., spice.

A strong qualitative theme also evident in survey results, and reflecting a similar finding by Higgins et al., (2020), was the rise in polydrug use and associated harms during the pandemic. While providers reported polydrug use had been evident before the pandemic, it was strongly believed that lockdowns had exacerbated the rise. Increased access to, and use of, counterfeit and prescription benzodiazepines was strongly linked to elevated levels of polydrug use. Concerns were raised about subsequent increases in related harms, including overdose, drug-related deaths, and developing dependencies on multiple substances.

> *Across all our services, we did observe an increase in polysubstance use with pregabalin and other prescription substances featuring much more often than pre-pandemic. 'Fake Xanax' also featured prominently in a number of reported incidents.*
>
> De Paul

> *Polydrug use has increased. People who are presenting now it's not just one substance. There may be a preference but it's generally people using two-three different, whatever's available at the time and the majority of people coming in to us would be drugs not alcohol which is interesting, and if it is alcohol it's alcohol and other things as well.*
>
> Carlisle House and Gray's Court

> *Whatever was available people used. So there wasn't and I know there's been a pattern of this anyway over recent years, people not having their clearly defined or defining themselves as, you know, 'I'm a heroin user' or 'I'm a benzo user', that's pretty much interchangeable. But that was kind of accentuated again within this people were just utilising whatever was available.*
>
> Simon Community

> *The inconsistency of substances [during COVID-19] has led to increased risk of overdose and higher prevalence of multiple dependence on various substances.*
>
> Regional Service User Network

Interestingly, three providers reported that patterns of polydrug use evident in the BHSCT were being replicated at a quicker rate in other HSCT areas during the pandemic. This change was attributed to drug markets and the increasingly transient nature of people who use drugs in the homeless community moving frequently between HSCT areas due to housing policy during the pandemic.

> *The other thing we've seen is a lot of the shifts within the community where people have moved from hostel to hostel and maybe been pushed out of an area for whatever the reason, they've brought their drug use and introduced it to the next hostel. And so what we've seen is, for example, heroin use going up and crystal meth going up and that's been partly because somebody else has introduced a new client group, or a new group of people, and that's where that has sort of sparked. 'Cause funny enough, so whenever we look at say, for example, the Western Trust side of things, it usually follows on what you'll find is Belfast, Ballymena and then it emerges somewhere in the west, sort of throws across the country like that and you can still see that happening, but it's coming faster. Stuff that was happening in Belfast yesterday might have taken a few months to hit the streets of Derry but now it's actually happening, because people are moving back and forth.*
>
> ASCERT Adult Services

> *What's been happening in the west, I think, is what happened in Belfast two or three years ago, the polysubstance explosion is now just happening, in Derry especially. We saw it two or three years ago in Belfast, meds too unfortunately because of it, people underestimating the risk of alcohol and various prescription or counterfeit prescription drugs [...] It's really, really challenging, and it's a combination of mental health, emotional wellbeing and an explosion, and I do mean, an explosion, in polysubstance use.*
>
> De Paul

Organisations working with young people discerned a large increase in other cohorts outside of the homeless community using multiple substances and alternative drugs during the pandemic which increased harm.

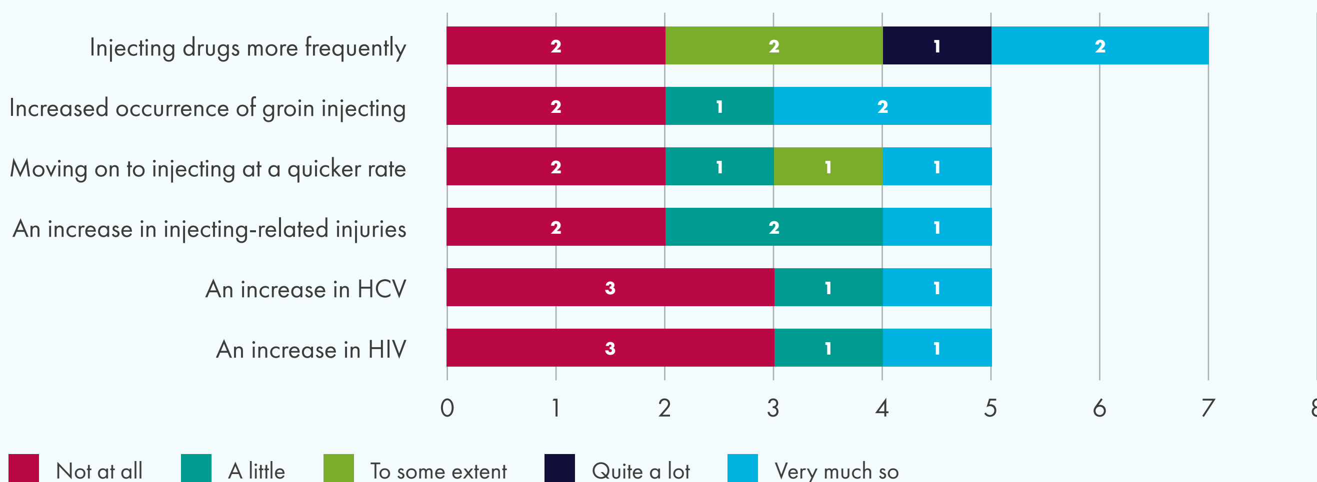
> *But see the amount of young people right now who are coming up on social media that are going missing, they're going AWOL, they're taking things which they don't normally take, they don't know where they are. It's frightening, it is really frightening so it is that this [COVID-19] has done this.*
>
> ASCERT Youth Service

5.3.5 Increased Injecting-Related Harm

Service provider data reported increased injecting-related harms within certain areas in Northern Ireland. Participating NIADA interview clients who use/d heroin either smoked (n=2) or did not report engaging in any injecting-related harm practices (n=2) during the pandemic.

Organisations were asked to what extent they had observed the below changes associated with injecting drugs during the COVID-19 pandemic. The 'not at all' results are likely linked to organisations who did not provide services to people who inject drugs or did not observe the changes listed during the pandemic.

Figure 46: Services Provider Reports on Changed Injecting Drug Use Practices and Harms



This graph excludes 'don't know' responses.

Figure 46 details service provider responses. About half of the organisations observed an increase in injecting frequency, with 30% noting a high increase. Increased groin injection was observed by 30%, with 20% reporting a high increase. A third found clients moving on to injecting at a quicker rate. Increased levels of injecting-related injuries were reported by 30% and an increase in HCV and HIV was observed by 20%.

Previous research had suggested changed injecting practices and related harms were due to increased injecting frequency, loaning and borrowing of injecting equipment and rising levels of injecting cocaine in Northern Ireland among people who inject drugs primarily in the homeless community (Croxford et al., 2021; Rintoul and Campbell, 2021; Campbell et al., 2021).

Qualitative findings from the current study identified similar issues during the pandemic, but they were predominantly confined to the BHSCT and SEHSCT, with some providers working in other HSCTs noting a small increase in injecting cocaine, heroin and related harms.

> *Our services in Western and Southern Trusts did not observe any increases in those specific areas [increase in injecting cocaine, groin injecting, HIV and HCV]. Our Western services did report some increase in heroin use among a small high risk cohort [aged below 30 years], but not specifically groin injecting.*
>
> **De Paul**

The growth of injecting-related harms in the BHSCT and SEHSCT was linked to increased numbers of people predominantly in the homeless community injecting cocaine which increased injecting frequency. The increase was also related to fluctuations in accessing preferred drugs, changing purity levels of drugs, reduced cost, and increased accessibility. It was also noted that there was a 'very limited amount of statutory service provision' (Extern) during the early stages of the pandemic as most statutory substance use services were temporarily suspended, including OST. Lengthy waiting times to access services such as OST combined with the aforementioned conditions led to some people substituting and/or supplementing opioid and other drug use with cocaine and other drugs.

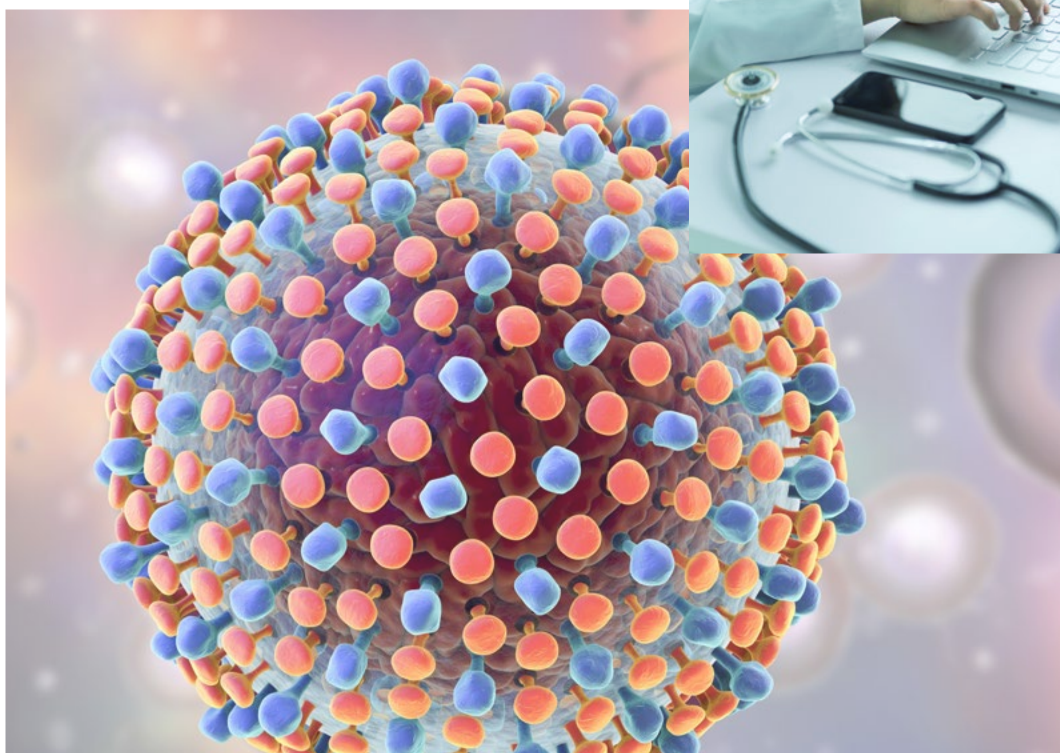
> *People who were working towards [opioid substitution therapy] initiation were told 'Well, actually, hold on we're stopping again'. The impact was that kind of window of opportunity was taken away and they kind of returned to more kind of chaotic drug use as a result.*
>
> Simon Community

Journal entries also noted the continuation of fluctuating heroin accessibility during fieldwork for this study which led some clients supplementing with cocaine.

> *Reported impacts on drug flow resulting in reports from clients of increased cocaine use due to reduction of heroin availability.*
>
> Simon Community

While the number of people injecting cocaine was small, the rise was significant given increased harms of stimulant injection. A younger, less risk-adverse cohort of inexperienced people were participating in this behaviour with some transitioning directly from other ways of taking drugs to injecting cocaine. Other studies (Rintoul and Campbell, 2021; Campbell et al., 2021; Higgins et al., 2020; ASCERT 2020) have identified increased prevalence of groin injecting linked with this cohort but the current study predominantly observed this behaviour in the BHSCT and SEHSCT.

> *We saw people injecting cocaine in greater numbers and people who weren't necessarily injectors prior to this kind of jumping from using pregabalin and Xanax and different things to injecting cocaine. Now that was really kind of Belfast and Lisburn-based, we didn't see that, you know, broader than that [...] The numbers of those injecting cocaine are relatively small, but it's a significant increase, even though it's relatively small. And these would be people who would not be kind of seasoned injectors anyway, so we saw some fairly nasty kind of injecting wounds as a result, you know, people's lack of understanding of how to inject in a safe way. Now again, in the areas where we would have seen that, Lisburn was the site where there was a real issue.*
>
> Simon Community



There's quite a lot more groin injecting [...] The staff teams themselves are reporting that the cohort are getting a lot younger and a lot of them are going straight for injecting into the groin which is obviously hugely concerning but that certainly has increased exponentially. And then obviously sharing needles too.

Extern

The inexperienced nature of this client group combined with a decreased interest and motivation to engage and implement safe injecting and other harm reduction strategies was highlighted.

Work that has been done with the service users around harm reduction I think has taken a massive hit off the back of the cocaine injecting because of the obvious you know issues in the sharing [...] I think the injecting practices have changed but also service users' kinda desire and need to or motivation to engage in that really robust sort of harm reduction work which they would all be kinda rolling their eyes at because they know it and they're listening to it day and daily when they're getting exchange and I think certainly from speaking to a couple of the staff team in isolation and for the younger cohort of service users that would kinda have gone to injecting cocaine relatively quickly into the groin. There seems to be more of a reluctance to engage in that kind of relationship-based harm reduction.

Extern

One provider noted that during the first lockdown community pressure and 'protests' (Extern) had resulted in the closure of a main NSES in the BHSCT. The NSES programme had been taken over by a NIADA organisation during the pandemic. Another provider noted that 'the static needle exchanges were not working as consistently as they had done, due to staffing issues' (Simon Community).

These issues with NSES combined with housing policy for the homeless community, restricted access to statutory substance use services during the early stages of the pandemic, combined with increased cocaine injection and related harms were associated with elevated levels of loaning and borrowing injecting equipment. Subsequently, HCV and HIV diagnoses increased within the BHSCT and SEHSCT.

The challenges of cocaine injecting and via the groin and the links between these issues to newly diagnosed HCV and HIV infections. Displacement of rough sleepers across NI removed people from their support networks, OST [opioid substitution therapy], needle and syringe provision, GP, mental health service etc.) NIHE [Northern Ireland Housing Executive] policy to 'End Rough Sleeping' in this way was poorly thought out and a major driver of the sharing of used injecting equipment in 'Dream Pod' type accommodation and therefore of the new HCV and HIV infections.

Extern

Because of the frequency of injecting cocaine and the need for additional sharps and how that sort of manifests itself over time if people are outside of where they normally would be if they've been placed in a Housing Executive or elsewhere and they maybe don't have access to needle exchange.

Extern

The rise in HCV and HIV was predominantly observed in the BHSCT and to a lesser extent in SEHSCT during the pandemic. However, there were concerns that the transient nature of the client group, sexual relationships and transactional sex may spread the viruses to other HSCT areas and the general population.

Outside of the Belfast area, we've not seen it [rise in HCV and HIV]. We've seen it definitely in Belfast, Lisburn, not really. We would always have had the likes of Ballymena, where we would have older guys inject and would have had Hep-C [HCV], particularly, that hasn't changed. But beyond that, no, we haven't really seen it. But I think it is definitely only a matter of time because of the transient nature of the guys we're working with. They're in and out of different hostels, moving area, and we're seeing even the relationships with people. We're seeing the potential for this to jump into the general population because the focus has been so much on the homeless injecting drug users in Belfast. But when they're in the hostel and they're having relationships with younger females who are sex working, in relationships with some of these guys and they're obviously working and having sex with people in the general population, and the opportunity for that to jump. It is only a matter of time. There is a need to broaden the scope from just looking at the homeless injectors to this kind of being an issue for everyone.

Simon Community

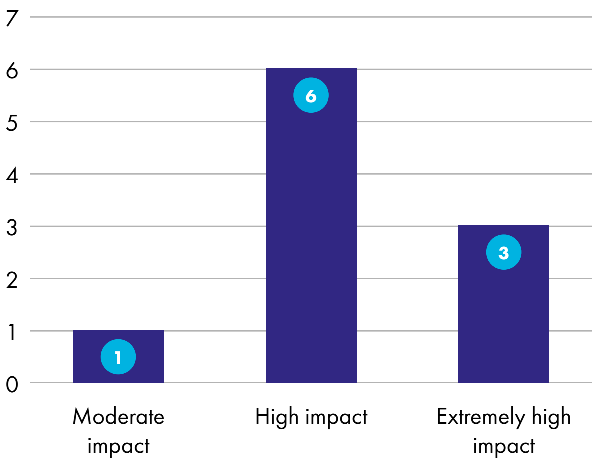
6. Impacts of COVID-19 on Service Delivery

This section presents results on the impacts of COVID-19 on service delivery from the perspective of providers, clients and family members.

6.1 Impacts on Service Delivery

NIADA organisations were asked to indicate if they had heard reports from clients or other providers about access to drugs, purity and cost since the start of the pandemic in March 2020.

Figure 47: Overall Impact of COVID-19 on Services

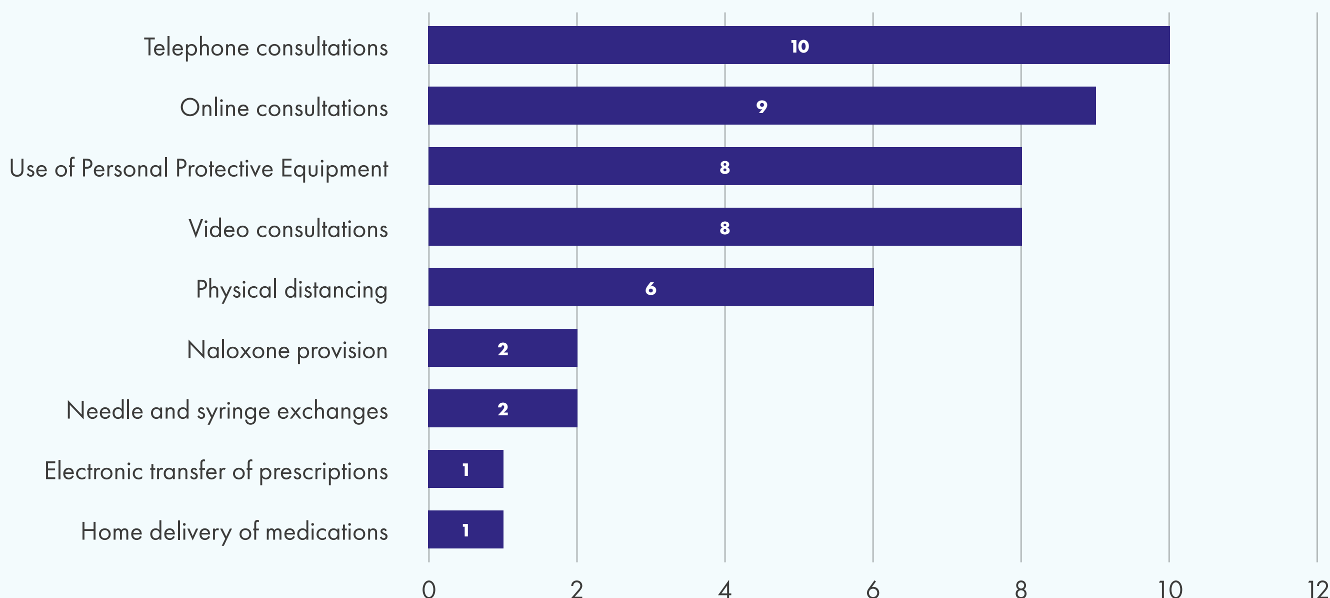


Two thirds (60%) of NIADA organisations reported a high impact of the pandemic on their services (Figure 47). A third (30%) stated an extremely high impact and 10% a moderate impact. Qualitative data explores potential reasons and indicates that the level of impact depended on the design and type of services and sites. Some were more amendable to implementing infection control measures and remote programme delivery in comparison to others (discussed later in this section).

6.2 Methods Employed Due to Infection Control Measures

To ensure implementation of COVID-19 infection control measures, NIADA organisations adopted and employed new methods. Providers were asked about these in the survey and the responses are set out in Figure 48.

Figure 48: Methods Used by Services to Implement Infection Control Measures

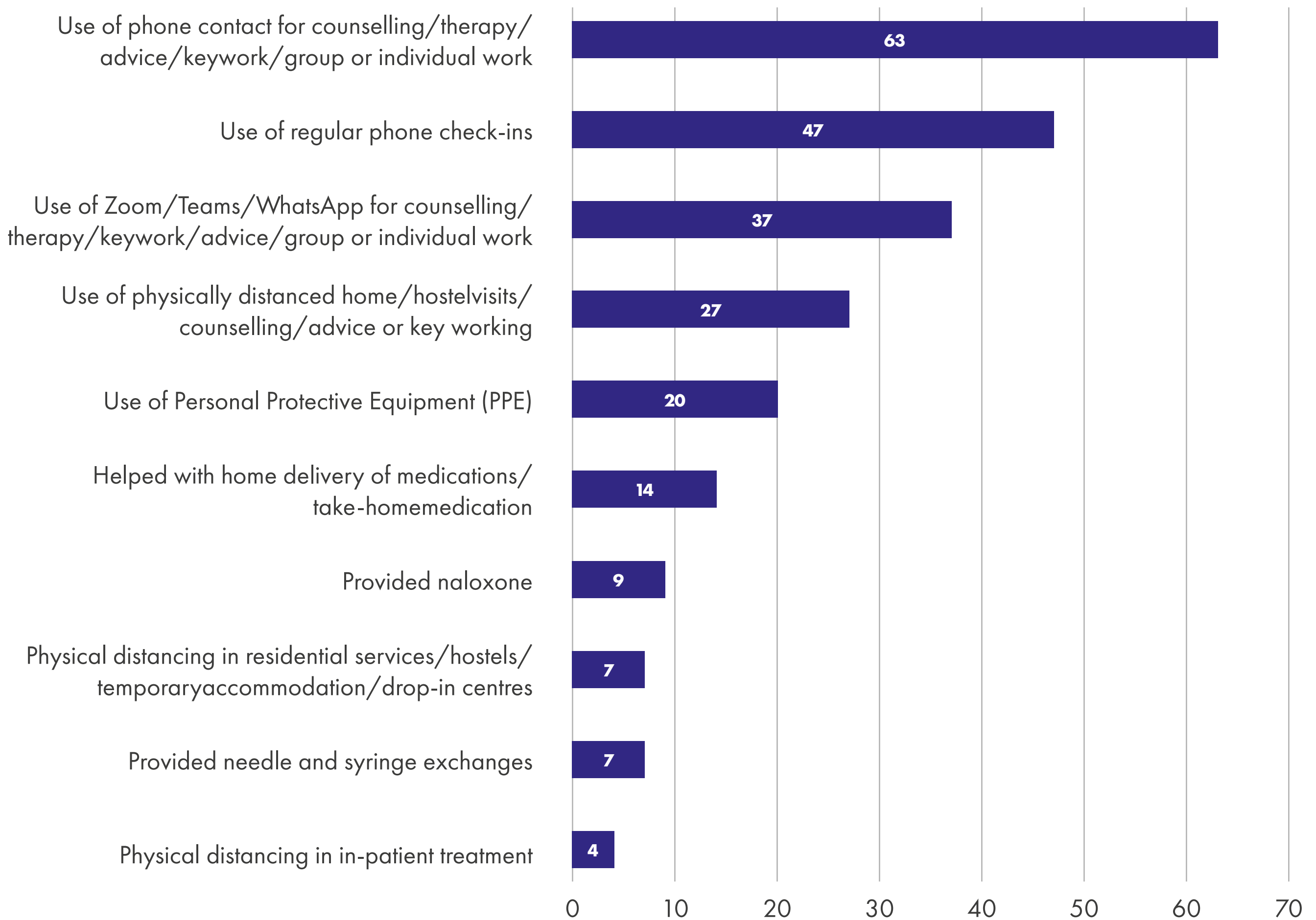


The majority of providers conducted consultations, counselling or key working by telephone (100%) and/or online (90%). The use of video consultations was not as high with 80% using this method. The use of Personal Protection Equipment (PPE) was also high (80%) and aided by 90% receiving PPE during the pandemic[47]. Social distancing was employed by 60%. There were lower numbers providing naloxone (20%), NSES (20%), electronic transfer of prescriptions (10%) and home delivery of medications (10%) which was related to the different services provided by the organisations.

Qualitative survey data indicated that some additional methods were used during the pandemic to meet client's needs. These included 'providing necessities to clients who were isolating' (Simon Community), online 'physical activity sessions, support groups and an educational platform' (ARC Fitness) and COVID-19 'vaccinations for both staff and service users' (Start 360).

[47]See Section 6.4.5.

Figure 49: Client Reports of Methods used by Services to Implement Infection Control Measures[48]



NIADA clients were asked to indicate which of the above methods were used by voluntary/community services they engaged with during the pandemic. Clients could select multiple responses. Figure 49 shows that over two thirds (64%) had used phone contact for individual or group services; just under half (48%) received regular phone check-ins from staff; using online platforms for individual or group work was experienced by 38%; continued use of socially distanced home or hostel visits by 28%; use of PPE by 20%; and help with home delivery of medications/take home medication by 14%. Lower numbers reported being provided with naloxone (9%), NSES (7%), using residential services/drop-in centres (7%) and in-patient treatment (4%). Other methods cited by NIADA clients in the survey were: the continuation of face-to-face support; getting cooked meals delivered; and, perplex screens being used during key worker sessions once services began to return to face-to-face delivery.

Ten NIADA clients[49] and all family members interviewed had used online video individual, group and family services. Counselling, key working and advice had been provided by phone contact to most participants. Four clients continued to use face-to-face harm reduction services such as outreach services and NSES which provided naloxone, sterile injecting equipment and tin foil. Two clients had engaged with in-patient residential rehabilitation services during the pandemic. Further qualitative findings on the effectiveness of new service delivery methods based on the perspectives and experiences of providers, clients and family members is presented later in this section.

[48]The graph is based on the number of responses and not percentages.

[49]One client had recently started to engage with a NIADA organisation and had not experienced remote delivery of services.

6.3 Challenges to Service Delivery

This section presents results on the challenges posed by the COVID-19 pandemic to service delivery. The rapid transition to remote delivery, implementing infection control measures, limitations of remote delivery and increased need for services are discussed.

6.3.1 Impacts on Services

Implementation of infection control measures affected many aspects of services provided in the voluntary/community sector. NIADA clients were asked to indicate their general level of satisfaction that changes made to services met their needs during the pandemic.

Figure 50: Client Reports on Satisfaction with Changes Made to Voluntary/Community Services[50]

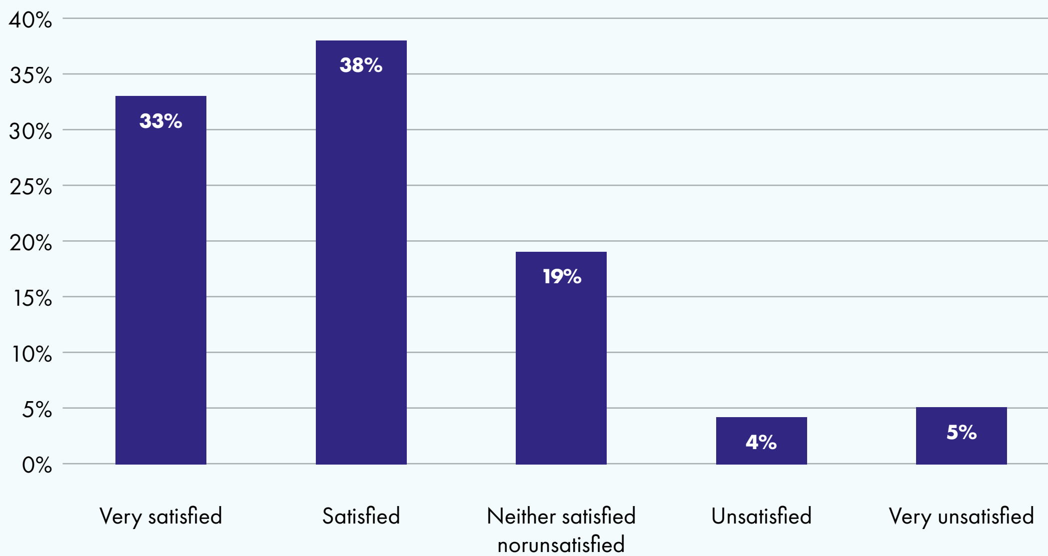


Figure 50 highlights that the majority of clients (71%) were satisfied that implemented changes to voluntary/community services met their needs during the pandemic. Just under a fifth were neither satisfied or unsatisfied and 9% were unsatisfied or very unsatisfied.

[50]There were missing responses due to not answering the question and a total of 94 valid responses.

Figure 51: Client Reports on Satisfaction with Changes Made to Voluntary/Community Services by Subgroup[51]

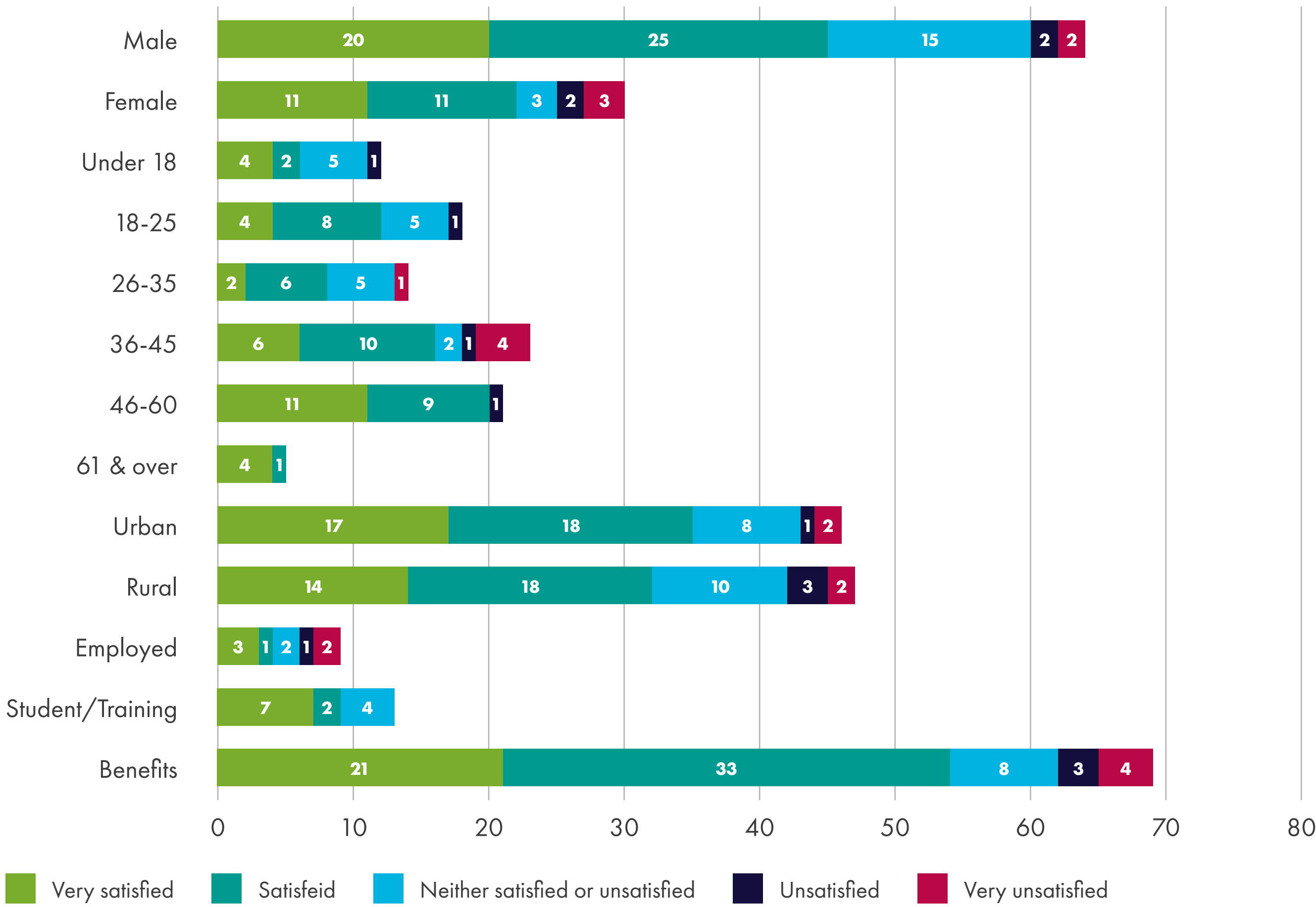


Figure 51 presents the NIADA client satisfaction rates by subgroup. With the exception of people who were employed and those aged under 18 years, the graph clearly illustrates that the dominant view for all other subgroups was being satisfied/very satisfied that changes to voluntary/community services met needs during the pandemic. While very small, the largest levels of dissatisfaction with changed services are located among people on benefits, those aged 36 to 45 years, women and those living in a rural location.

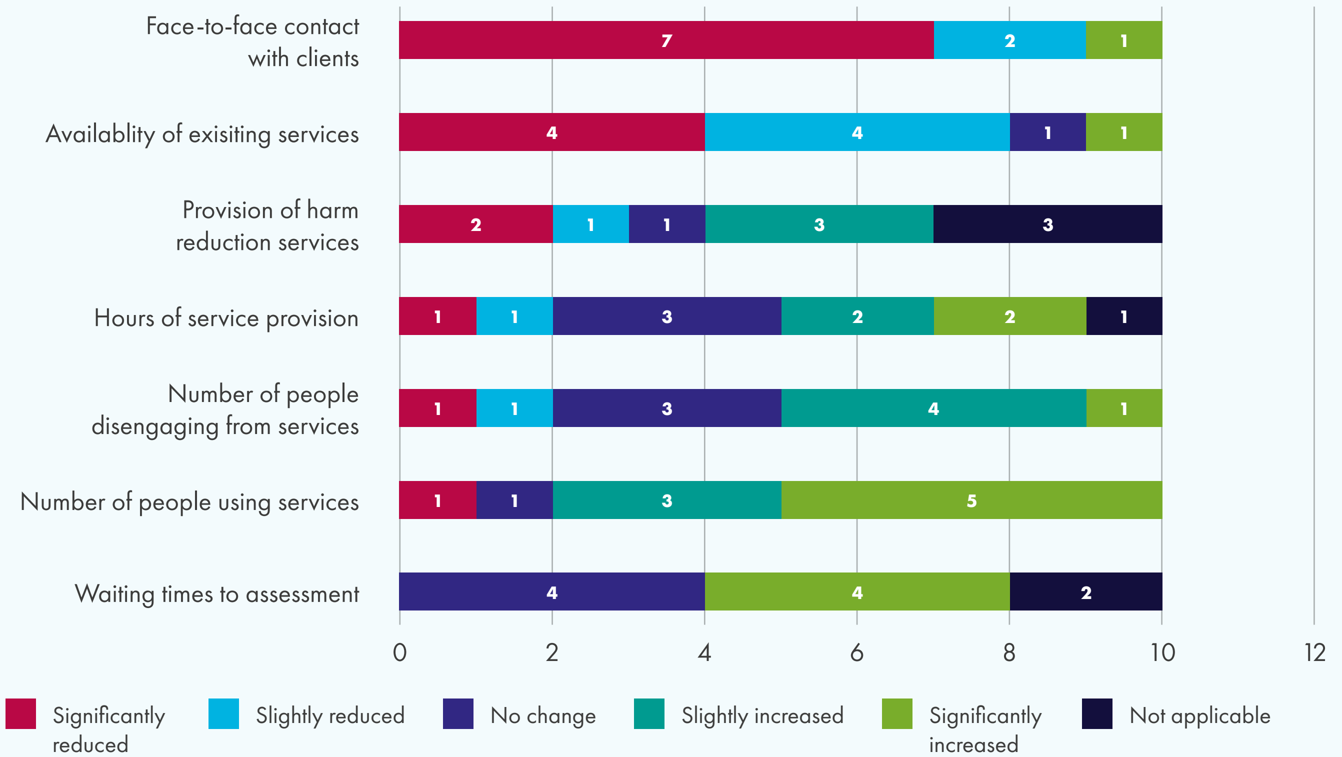
There was also a statistically significant relationship between age and levels of satisfaction. Clients who were neither satisfied or unsatisfied were significantly younger than those who were very satisfied that changes to voluntary/community services had met their needs during the pandemic.

This finding may be related to younger people having less experience with services and associated lack of confidence in answering the question and judging how they felt about changes.

In the provider survey, NIADA organisations were asked the extent to which various aspects of service provision listed in Figure 52 had reduced or increased since the beginning of the COVID-19 pandemic. Variations related to the types of services provided by the organisations, subsequent client groups and the extent that COVID-19 infection control measures impacted service delivery.

[51] There were missing responses due to not answering the question and a total of 94 valid responses. The graph is based on the number of responses and not percentages.

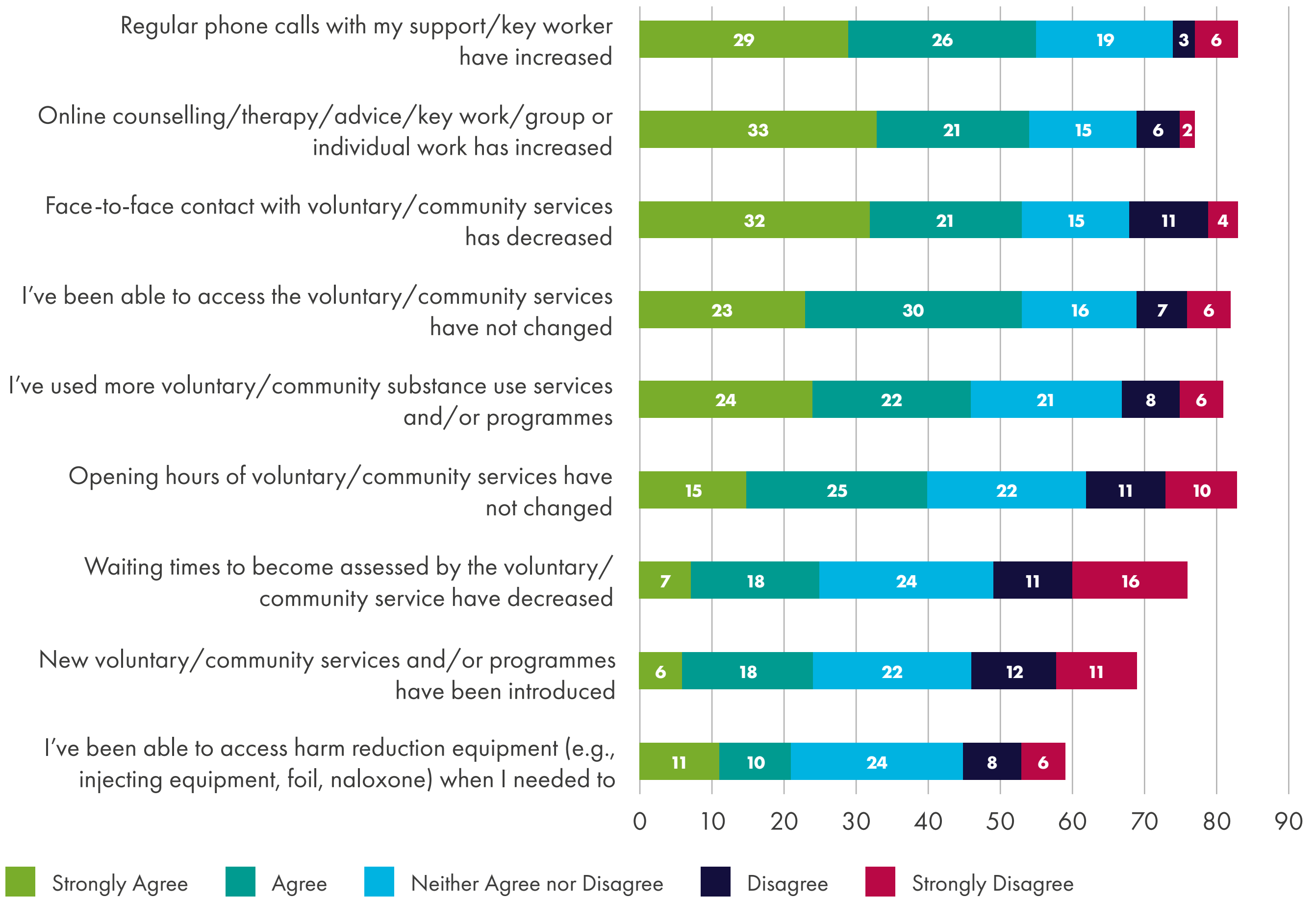
Figure 52: Service Provider Reports on COVID-19 Impacts on Aspects of Services



As shown in Figure 52, the majority of providers reported reduced face-to-face contact (90%) and availability of existing services (80%). Reduced provision of harm reduction services/ equipment was reported by 30%, compared to 10% stating no change and 30% observed a slight increase. There was a slightly higher number of providers noting increased hours of service provision (40%) in comparison to no change (30%) or a reduction (20%). A greater number observed increased numbers of people disengaging from services (50%) in comparison to a reduction (30%) or no change (30%). The majority (80%) reported increased numbers of people using services. Regarding waiting times to client assessment, 40% reported no change and 40% noted an increase.

In the client survey, participants were asked about their experiences with services in the voluntary/community sector and how much they agreed/disagreed with the below statements.

Figure 53: Client Reports on Experiences with Aspects of Services Impacted by COVID-19[52]



The graph excludes results for 'not applicable' answers.

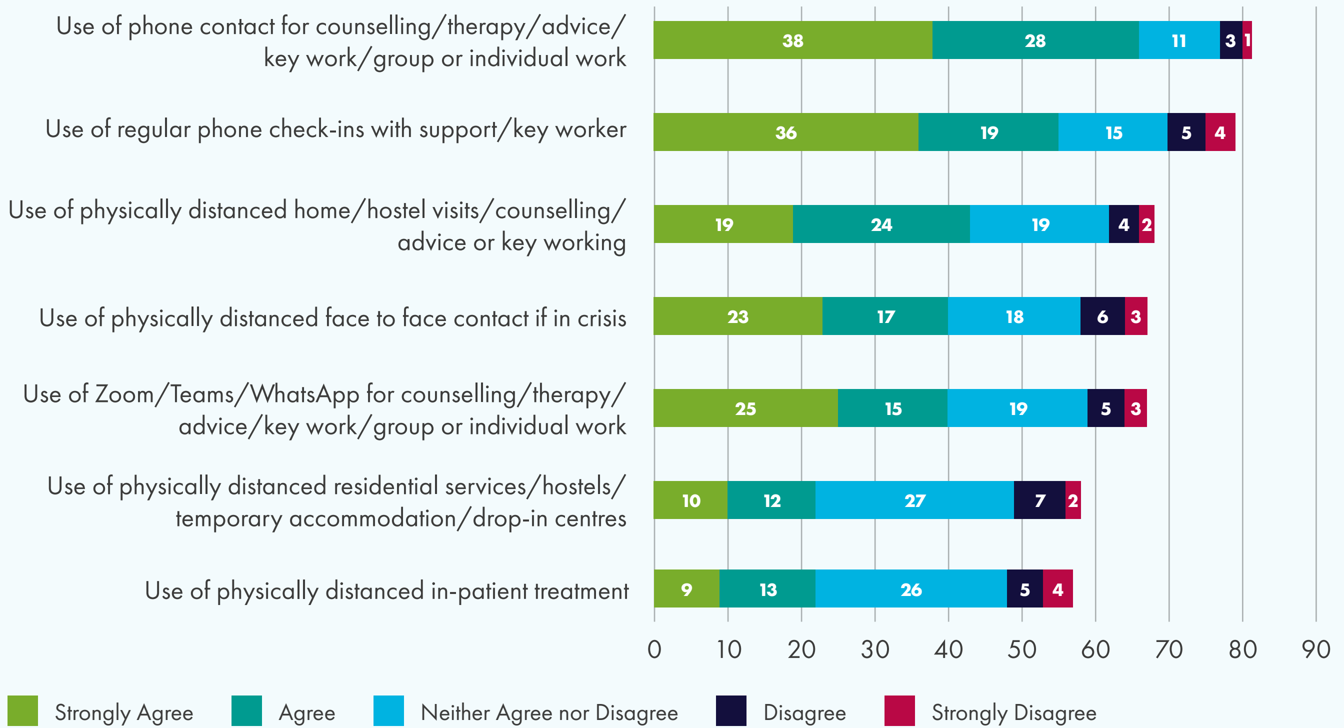
Similar to provider results, Figure 53 shows that most participants agreed/strongly agreed that regular phone contact with support/key worker (66%) and online individual and/or group work increased (65%) while face-to-face contact decreased (64%). Most clients accessed mental health support (64%) and substance use services (55%) from voluntary/community services when necessary. Just under half (48%) agreed/strongly agreed that opening hours of services had not changed during the pandemic while almost a third (30%) experienced reduced waiting times to assessment or were unsure (29%) or experienced increased waiting times (31%).

New voluntary/community services or programmes were reported by 29% with 26% being unsure and 27% reported experiencing no new services. A quarter mentioned access to harm reduction equipment which links to the low numbers of people who would have needed this service participating in the research.

NIADA clients were also asked the extent to which they agreed/disagreed that the changes to services listed below had met their needs during the pandemic.

[52] There were missing responses due to not answering the question and a total of 83 valid responses. The graph is based on the number of responses and not percentages.

Figure 54: Client Reports on Ability of Changed Services to Meet Needs During the Pandemic[53]



The graph excludes results for 'not applicable' answers.

Figure 54 illustrates that the two most popular methods for meeting needs during the pandemic were phone contact for individual or group services (66%) and regular phone check-ins with support/key workers (66%). The use of socially distanced home/hostel or in person services met the needs of over two thirds (63%). The majority (59%) agreed/strongly agreed that using socially distanced face-to-face contact when in crisis and online video platforms for individual and group work met their needs. While less participants used socially distanced temporary accommodation/drop-in centres and in-patient treatment, 38% agreed/strongly agreed these services met their needs during the pandemic.

The diverse range of needs which NIADA clients presented with during the pandemic is likely to account for the variations in findings detailed in this section. Variations are also connected to the diverse range of services provided by NIADA organisations with some being more amendable to changed service delivery methods than others. However, survey results do indicate the important role which the voluntary/community sector fulfilled in the provision of substance use and mental health support and services during the pandemic when access to primary and statutory services was constrained (also noted by Higgins et al. in 2020). Results show that the changes in delivery did meet most clients' needs during the pandemic with phone, continuation and/or reinstatement of some face-to-face services and online video services being particularly useful. Qualitative thematic findings on these issues are discussed in the following subsections.

[53] The graph is based on the number of responses and not percentages.

6.3.2 Rapid Transition to Remote Delivery

All relevant providers said that rapidly transitioning to remote service delivery created substantial challenges especially given increased demand for services. This change required upskilling staff to deliver programmes remotely which was challenging during the initial stages of the transition.

> *I've an awful lot of knowledge in phone work but we had a whole team of people who had probably never done anything else expect face-to-face work and they needed to be upskilled in what it's like because it's a different piece of work whenever you're working with someone on the phone and you don't have the visual connection with the person, not just for feedback, but also to measure risk and all of those things. So, there was a lot of work needed done in terms of making sure people were upskilled quickly in how to deliver this type of work, especially in the sort of challenges we are in [...] It certainly created more work for us, but it also upskilled everybody as well as, we had to, and of course, they all had to, myself included, learn how to use this sort of technology very, very quickly.*
>
> ASCERT Adult Services

Providers emphasised how staff worked cohesively and collaboratively ensuring the move was as seamless as possible. For some staff, the pressure of new service delivery methods combined with the impacts of COVID-19 on their personal life (e.g., home-schooling, caring roles and vulnerability status) and/or health led to temporarily or permanently leaving jobs.

Rapid adaption and implementation of policies and procedures to protect staff and clients was emphasised. It was vitally important to create a 'supportive work environment' (Simon Community), adopting flexible working hours and regular remote team building activities to maintain staff morale and ensure organisations were aware of any issues affecting employment as illustrated in the following quotations:

> *Our staff are amazing, and our organisation, from the minute that it [COVID-19] hit, we knew what we were doing, we had solid policies and procedures to keep our staff safe but we allowed them to continue doing their job and for us, for me, it's how our organisation responded, from our board down and then how our staff responded, our staff continued to do their job [...] One of the things that our organisation tried to do during COVID was make sure that staff were okay and we were saying to them, 'Do what you can do, we know you're at home with family, we know you're at home maybe caring for, we know all that, so just do what you can do.' Because you weren't very aware of the impact on your staff as well and trying to continue to support their caseload and stuff. Amazing, like [staff] really stepped up and stood out, they were amazing.*
>
> Start 360

> *We had Teams meetings and stuff, a coffee morning, just for a check-in with everybody, to talk about football, to talk about just how they're getting on and sort of keeping people connected, because it's whenever people disconnect, and you feel disconnected, that that's the problem.*
>
> Dunlewey Addiction Service

6.3.3 Implementing Infection Control Measures

The implementation of PPE and social distancing affected all providers given the previous dominance of face-to-face delivery. Challenges surrounding initial shortages of PPE, technological devices and implementing social distancing and masks into daily work practices for both staff and clients were emphasised. For example, learning how to 'project' voices while wearing masks (Carlisle House and Gray's Court). Other providers noted how facemasks were 'a barrier to non-verbal communication' (Start 360) especially for young people and children. During the early stages of the pandemic, one provider noted that clients previously subjected to paramilitary attacks found masks 'retraumatising' (Dunlewey Addiction Service). Other organisations stated some clients expressed suspicion as to why masks were being worn by staff.

> *The wearing of masks, sometimes there was negative assumptions made because of their own perception of themselves, you know, 'Are you fearful that I'm going to infect you?' Those ideas, I think, were certainly difficult to navigate through at times.*
>
> Simon Community

Implementation of COVID-19 infection control measures also affected some services more than others given differential programmes and sites. The most affected services provided programmes in prison settings, supported living accommodation, hostels, day centres, and in-patient rehabilitation. Despite the challenges, services innovatively changed, developed and adapted services to ensure compliance with restrictions while maintaining delivery of programmes where possible. For example, one organisation noted the transformation of a day centre into an outreach service within a 24 hour period.

> *When you think about the [homeless drop-in] day centre, it was converted in the space of 24 hours from a drop-in centre, where upwards of 40 to 50 people might attend in a day, to being an outward, outreach service, where we were providing meals on wheels, visits to people's homes, checking in on 30 to 40 of the most vulnerable, that happened within 24 hours.*
>
> De Paul

Another organisation providing in-patient rehabilitation services closed for two months but reopened with a reduced programme length, redesign of some programme elements and strict infection control protocols. While restrictions had reduced the capacity of the programme to between 50% to 75%, it was able to continue to operate successfully.

> *We made the programme more intense so it runs over the weekends as well and cut the length of the programme. So, we had the same number of people roughly, well not quite, maybe two thirds of the people can access it even when we were under fifty percent.*
>
> Carlisle House and Gray's Court

Two NIADA clients had engaged with residential rehabilitation services affected by these infection control measures. While satisfied with reduced programme length and finding the programme very beneficial, one client recalled the impact of restrictions contributing towards feelings of isolation and loneliness.

> *The restrictions that were put upon the clients who were within the system, be it [voluntary organisation] or [voluntary organisation], there was definitely major restrictions in that lack of community involvement, lack of family involvement, you really did feel completely and totally isolated. And that was obviously for the best reasons and intentions and that was based purely on the fact that they couldn't come in. That physical interaction, very much so, was missed because I have [children] as well. And so I'd say the lack of interaction most definitely had an impact, for sure. I think they were very restricted in what they could do, governed by the government guidelines.*
>
> 11, Male Client, mid 50s

6.3.4 Limitations of Remote Delivery

Qualitative data identified a number of challenges with remote service delivery. Key themes were: technological barriers; extra resources needed to deliver services; concerns about confidentiality and anonymity; fully assessing, managing and addressing risks; the impact on trust and rapport; and preference for face-to-face delivery of services.

For some clients, digital inequalities created barriers and 'increased anxiety and isolation' (Simon Community). Given these problems, engagement with some services had either decreased or was problematic during sessions. Challenges were particularly pronounced for people in the homeless community, on probation, older people, people residing in rural locations and those with limited technology knowledge or resources.

> *The services have turned to telephone and to online platforms in order to deliver support to clients and not everybody has those, especially the online platforms, access to those, whether it's the right sort of phone or whether it be a tablet or computer or the internet itself [...] You've also got the fact not everybody has a mobile phone or has access or a good place where you can get a signal. Within our work in the probation service, you've also got people who, because of their offences, aren't allowed a Smartphone of any sort of description, or in some cases, not even allowed a phone, that there's a barrier as well. And of course then where you are, using Zoom or some of those other platforms, where broadband simply isn't good especially in rural areas, connections are very, very poor.*
>
> ASCERT Adult Services

> *I suppose for somebody like [adult child] who needs that one-to-one and that face-to-face, that's not available. Now I do know that [adult child] has linked in with the likes of [voluntary organisation] and for a time there he was going to [independent peer support group] but it moved online and it's alright for me because I've got an iPad but [adult child's] wandering about, leaving possessions all-round the country [because of homeless]. That, again, is not an option.*
>
> 02, Family Member

> *We would have tried to continue doing the course. Sometimes it would have been hard, you're depending on other people's network, you're depending on no interruptions, it can, some days, just not work.*
>
> 11, Female Client, mid 40s

> *People maybe weren't very tech-savvy, some of our service users, then it was really difficult for them and also people who, and generally the older population, who would have really struggled with that technology and didn't really like it and really and then that put them off [engaging] further and then they were further disadvantaged.*
>
> Extern

> *A number of young people, especially from the Roma community, were unable to engage because of lack of technology, laptop or mobile phones, as well as living in rural areas.*
>
> Start 360

To overcome these barriers, providers adopted regular phone check-in's with clients, tailored services to client needs as much as possible, secured funding for technological devices for clients and completed face-to-face visitations where possible.

> *Those guys who were already isolated they would have struggled with, or maybe hadn't any consistent access to internet. So that was something that we got a bit of funding for, to get people phones, tablets, the dongles that allow them to kind of get access to internet. But we really kind of saw the impact on those people.*
>
> Simon Community

> *We do have some service users who don't have internet access. Even if they do, they're too fearful even to go on to it. Also, maybe don't have the signal either because some of them live out in the country. As a result of that, because they weren't able to participate in our Zoom recovery programmes or any of the other classes and so on that we ran throughout the pandemic, we did more check-in calls with them, really just to check in to see were they okay, was there anything that they needed.*
>
> Davina's Ark

In addition, some face-to-face sessions were redesigned into shorter, more frequent video or phone sessions and additional, regular 'check-in' phone contact implemented. However, these extra services extended opening hours and workload for some organisations when resources were already strained.

> *People don't tolerate an hour's session on the phone or an hour's session on Zoom, it's maybe not something that they can do. We have broken services down into more manageable bite-size 15, 20-minute chunks. So, the person is getting maybe three or four check-ins like that a week or maybe a couple like that a week, so again, it's tailored to what they need.*
>
> ASCERT Adult Services

Due to the demand on our services, we did increase our working hours, from Monday to Sunday from eight in the morning to ten at night, to cope with the demand for calls and so on, and also as well too to enable us to do the check-in calls at the weekends.

Davina's Ark

Concerns were raised about maintaining confidentially and anonymity using remote delivery methods as it was sometimes unclear if the person was alone. This was a particularly problematic issue for people living in communal residencies.

Confidentiality and privacy has been a huge one, especially for people maybe in hostels or living in a very crowded house where they've very little private accommodation at all, if any [...] Trying to work with a person on the phone, who maybe had somebody in the background, and you're trying to ensure confidentiality, trying to ensure safety and all the stuff that's going on within that and so it probably made work a lot harder for practitioners in many ways.

ASCERT Adult Services

Importantly, providers noted that not being physically present with clients inhibited the ability to fully assess if a person was using substances, needs and potential risk. Lack of face-to-face interactions were deemed particularly problematic for people in crisis including those expressing suicidal ideation and thoughts of life not worth living.

The other side of it is we can't always see them, they've been smoking away or drinking away even when on the calls, and thinking we don't know.

ASCERT Adult Services

Face-to-face would mainly be better. Over the phone, you could be sitting, doing one thing and saying another. Face-to-face they can look at you and see.

13, Male Client, early 30s

We found that if you're in a counselling setting and your client becomes visibly upset, you can sit with them in that space and ensure that before they leave the session, before they leave your building, that they're okay. On Zoom, when you're on with a client and they get visibly upset or distressed, yes, you're in that space, but it's extremely different and you do feel that gap between the two of you. They can go off-screen and just leave and you're left wondering 'Are they okay? How are they going to be?' And then phoning them to check in, to make sure they're all right, so that safety aspect as well, I found quite challenging over the course of the pandemic, and some of my colleagues as well would say the same. The same too also with the group forum.

Davina's Ark

Some clients also stated that they and their peers were more open and honest about their substance use and needs when engaging face-to-face in individual and group programmes. Therefore, telephone and online methods may potentially have affected providers' ability to fully understand potential risks and needs.

I am aware I can hold back a certain amount when I'm on my [remote] one-to-one. I am aware talking on the phone, I can be, 'Yeah it's fine, it's fine', as where I'm in person-to-person I find it harder to hold back, I would be a bit more open.

15, Female Client, mid 40s

[Voluntary organisation] used Zoom but it didn't really work. People don't really like speaking out. It is much better face to face. You can get to know the people better and people feel more comfortable speaking about themselves. Some people are shy, they don't want to talk, you can see people on the screen but you can kinda of get a gauge best by seeing them in person.

06, Female Client, mid 40s

To overcome these challenges, some providers adopted regular phone check-ins, and continued to deliver some socially distanced services. For example, providers working with young people adopted a 'walk and talk' (Start 360) approach. This service provision was and continued to be provided to those most at risk of harm and subject to organisational risk assessment.

Our staff didn't stop doing face-to-face, face-to-face continued right throughout COVID, because it's very difficult to do a telephone intervention with somebody who is at serious risk to life, you can't do it, they need to see you. They didn't want to talk to somebody else on the phone, they need to see you, so you were continuing to provide that face-to-face right throughout that period.

Start 360

I think one of the big challenges is at the minute because so many young people are in crisis right now, trying to meet their needs all the time, like in relation to going and seeing them is difficult. And those face-to-face protocols are in place, but it's not all the time [...] There is such an increase at the minute of complexities of cases and sometimes a person just needs to be there in front of you.

ASCERT Youth Services

Providers of low threshold services also continued to provide socially distanced face- to-face services to mitigate potential drug-related harms among people in the homeless community, people in the community who used drugs and/or without appropriate technology to engage in remote services. Services included access to sterile injecting equipment, BBV testing, injecting wound care, naloxone, basic health and subsistence checks.

> *While all the services kind of withdrew and were doing remote contact, we made the decision to continue to support the most vulnerable, face-to-face, obviously taking all the precautions we could, but even from the perspective of doing health checks, and just to see were they okay, did they have enough food, fuel, everything like that.*
>
> Simon Community

Providers and clients drew attention to missing the social and human connectedness involved with face-to-face services. Being physically present was deemed very important to communication, building relationships and developing trust and rapport between clients and staff or peers ensuring effective initial assessment and delivery of programmes.

> *The biggest problem was the fact we could not meet face-to-face and the group work was carried out either over Zoom or WhatsApp. For any new young person, this was stressful, for some it was hard to build a relationship, and to talk about their issues with a person they had never met bearing in mind we work with children and young people from 8 to 18 [years].*
>
> Start 360

> *It's harder to communicate with people not in the same room as you. So it would just be harder to maintain the close relationship like [...] I've tried counselling over the phone, and for all the will in the world of both parties, you can't. You need a connection during counselling of some kind and it's really hard to build that over the phone, really hard to build.*
>
> 16, Male Client, early 40s

> *There's people I would chat with when we were in person, that I wouldn't necessarily talk to from one end of the week to the other or would ever see because they're from a completely different part of [place in NI] [...] So, the interaction with that person would only be at the coffee table and it might only happen once a month but it will never happen while it's on Zoom but that wee interaction is where you make connections. It's all very uniform online. You've to wait for your turn to talk. And I suppose that's that social connection I talk about missing.*
>
> 15, Female Client, mid 40s

Qualitative data shows varied preferences for remote services dependent on the client group and individual needs of people engaging with services. Some young people preferred 'text or Zoom calls' (Start 360) in comparison to phone support. While understanding and experiencing benefits from remote delivery[54], a return to some form of face-to-face delivery was supported by clients and providers who took part in interviews.

> *For some people we've noticed actually it [remote service delivery] has worked well, but for other people especially those who are socially isolated, and those who have trouble with phone calls and limited access to online programme support, they've really, really struggled and have really said to us, 'Listen now, I'd love to be back in the face-to-face again, seeing a real person again and coming out.' So, it's mixed but the majority of people would prefer to be back into some sort of face-to-face contact.*
>
> ASCERT Adult Services

> *I would rather we went back to what the way it was before. Yes, I will use Zoom, the telephone, yes [...] But I would rather get people in a room and just sit down with a cup of coffee because this is where we work best, we work best when we're with each other.*
>
> 19, Female Client, early 40s

[54]See Section 6.4.1.

6.3.5 Increased Need for Services

As discussed in Section 4, providers reported several health and social impacts[55], changes in drug markets, use and related behaviours[56] which either emerged from, or, were exacerbated by, the COVID-19 pandemic for specific populations of clients. These impacts increased the complexity of some clients' needs and required different and/or more varied health and social care services. In this context, presentations and referrals to most NIADA organisations had increased. The following quote illustrates the views of a number of organisations:

Last year all the services were oversubscribed throughout, there was more people looking for them [...] Our work increased as more and more people were contacting us, worried about this one, worried about that one, and, again, it put more pressure on the services.

ASCERT Adult Services

The provider survey asked NIADA organisations to what extent they had observed a greater need for the below substance use services among clients since the beginning of the COVID-19 pandemic. Providers were also asked about rates of clients attempting to self-detox during the pandemic given that high levels potentially indicated issues accessing statutory drug treatment services.

Figure 55: Service Provider Reports on Need for Services and Levels of Self-Detox

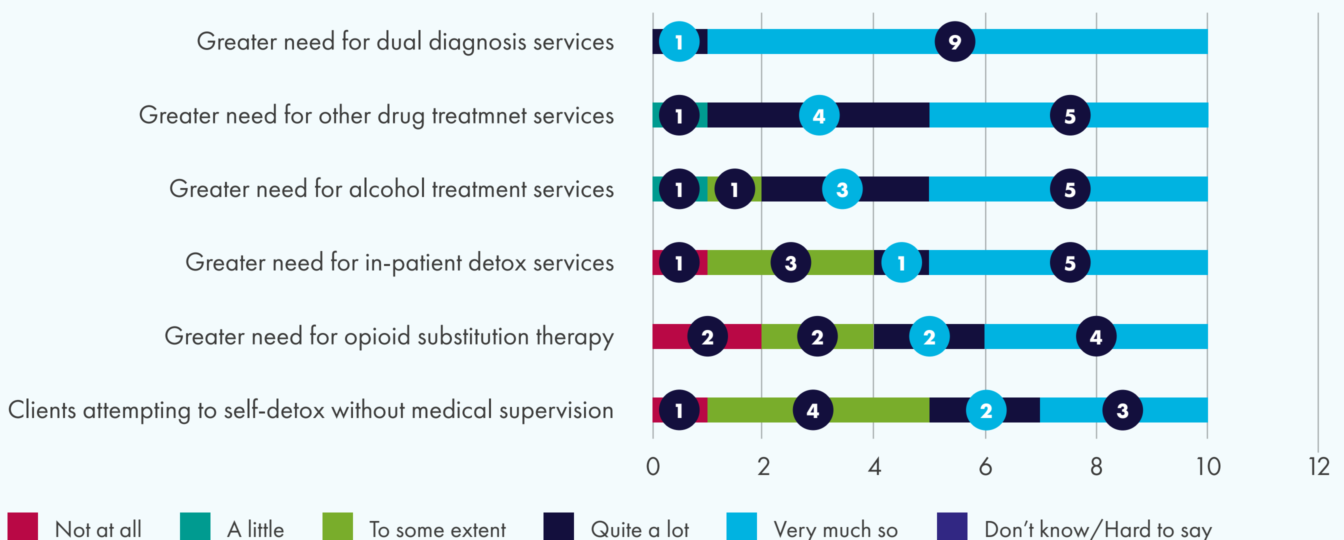
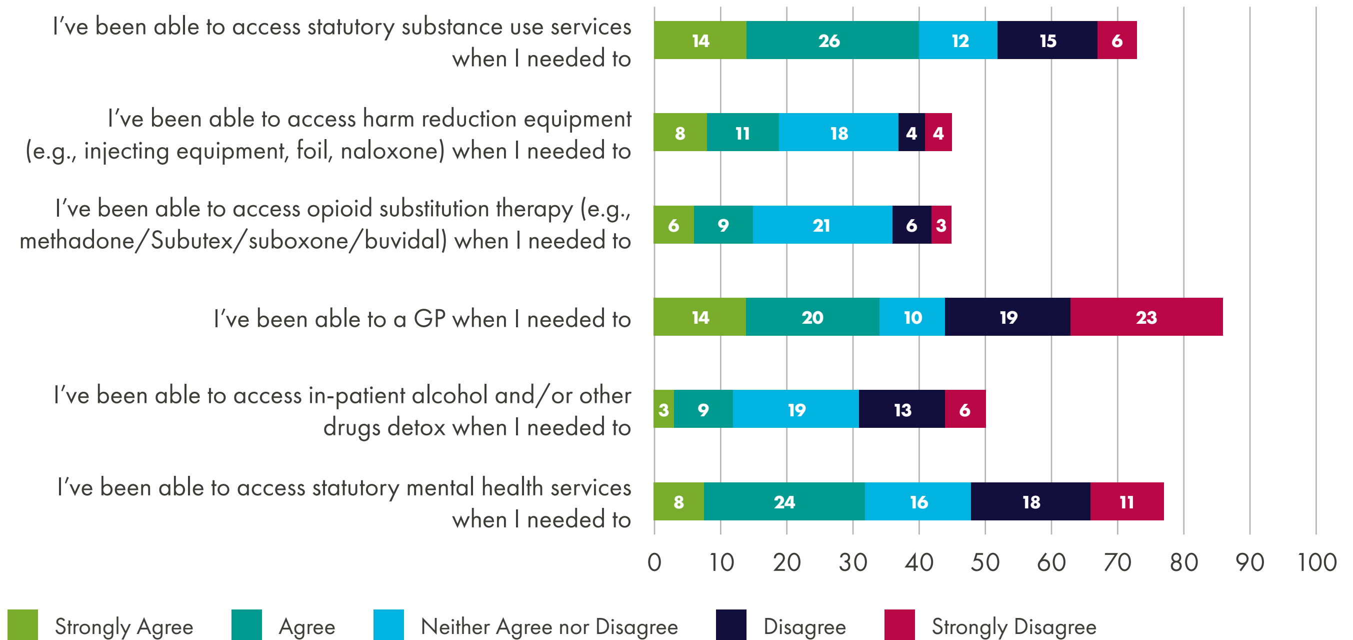


Figure 55 highlights that all organisations reported greater need for dual diagnosis, alcohol and other drug treatment services during the pandemic. A majority (90%) also observed greater need for in-patient detox. Increased need for OST was reported by 70% and 90% observed increased levels of clients self-detoxing. High rates of self-detox indicate potential issues accessing statutory substance use services during the pandemic as they provide medical detox and OST.

Most services highlighted in Figure 55 are provided by the statutory substance use sector in Northern Ireland. Given provider results, in the client survey participants were asked to what extent they agreed/disagreed with the below statements about accessing statutory services during the pandemic.

[55]See Section 4.
[56]See Section 5.

Figure 56: Client Reports on Accessing Statutory Services During the Pandemic[57]



The graph excludes 'not applicable' answers.
*E.g., injecting equipment, foil, naloxone; **E.g., Methadone/Subutex/Suboxone/Buvidal.

As can be seen in Figure 56, over half (55%) of NIADA clients were able to access statutory substance use services when they needed to during the pandemic. Harm reduction equipment was accessible to 42%. Just over a third (33%) reported being able to access OST when they needed to. Almost half (49%) were unable to access to a GP (49%) or in-patient detox (48%) when necessary. Almost two thirds were unable to access statutory mental health services (58%) when they needed to.

As numbers are small, results should be treated with caution but they indicate that access to some statutory services was affected more than others during the pandemic. For example, some statutory drug treatment services were temporarily suspended during the pandemic but reinstated during the fieldwork stage of this study increasing accessibility. However, suspension of services had increased waiting times for some services. Low numbers experiencing good access to other statutory and primary health care services suggests possible issues with remote delivery and/or adaptions to services. Lower numbers accessing statutory mental health services may be connected to the absence of dual diagnosis services in Northern Ireland.

[57] The graph is based on the number of responses and not percentages.

Qualitative findings revealed issues resulting from the lack of face-to-face GP appointments, restricted presence of social services, longer waiting times to be inducted onto OST and other statutory substance use treatment services, temporary suspension of some statutory services, and concerns about accessibility to mental health and substance use services. It was felt that during the early stages of the pandemic, priority was given to COVID-19 related services within the statutory sector to the detriment of important substance use and mental health services.

> *I understand this pandemic came totally out of the blue. They've never had anything in our lifetime or our generation anything like this. They were being just reactive to what was going on, and I can understand how other things were set aside but I suppose the key lesson is that if something ever happens like this again, that there are other health and mental health issues that should not go by the by just because there's a pandemic [...] I understand why it was very important for them and critical that COVID was given priority, but that shouldn't have been to the detriment of the mental health and other health issues of those who really need help.*
>
> 02, Family Member

NIADA organisations generally reported a good working relationship with statutory services in their respective HSCT areas, but there were frustrations. Given increased demand for services during the pandemic, constrained statutory provision increased pressure on the voluntary and community sector. There was a view that statutory services should have adapted and remained fully operational throughout the pandemic given increased demand for services. One organisation also noted that offers to help statutory services deal with some of the presenting issues were turned down.

> *I think they [statutory services] could have given us more responsibility to deliver services we were able to deliver, like OST and so on. We had offered to support people to access that service to ensure people were getting scripted and that wasn't possible.*
>
> Extern

> *It almost felt like some of the statutory drug services disappeared, it was as if they just disappeared, went into thin air and you couldn't find them.*
>
> Start 360

> *It was like they [statutory drug treatment services] were able to hide behind COVID and all the risk was put onto the community and voluntary sector.*
>
> Dunlewey Addiction Service

Clients engaged with, or, referred to statutory substance use services noted substantial changes to service delivery, some of which were positive[58]. However, as outlined in Section 6.3, new referrals experienced lengthy waiting lists and delays from initial assessment to engagement with many services not being adapted to a remote delivery form. Delays were also attributed to staff shortages due to redeployment, sick leave or having to isolate.

> *With regard to accessing [statutory substance use treatment services] and stuff like that, a lot of their face-to-face things got done away and it would only sort of work face-to-face. So, there was appointments postponed and delayed and people, having to go off or whatever or isolate themselves. So, staff shortages on the sides of the services were quite apparent.*
>
> 10, Male Client, early 40s

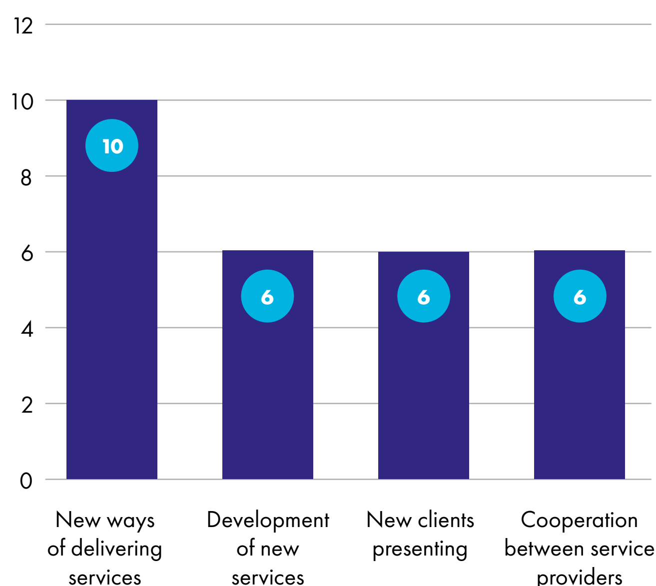
[58]See Section 6.4.1.

6.4 Positive Impacts on Service Delivery

The pandemic also had positive impacts on service delivery including service delivery methods, new clients, cooperation between providers, support and funding.

In the provider survey, NIADA organisations were asked if there had been any positive impacts of the pandemic listed in Figure 57 on their services.

Figure 57: Positive Impacts of COVID-19 on Services



6.4.1 New Service Delivery Methods

The most positive impact identified by providers in Figure 57 was new ways of delivering services. While limitations of remote delivery have been highlighted in Section 6.3.4, qualitative data also emphasised the effectiveness of these methods and other adaptions of programmes.

Organisations using remote delivery and families and clients who experienced these methods reported benefitting from their accessibility and flexibility. The methods reduced travel costs and time enhancing engagement with services.

> *Sometimes it's nice just to be in your own house and you don't have to travel, cause sometimes if you have to actually go somewhere. It can be off-putting if I have to travel an hour in the car to go to a two hour meeting to drive an hour home in the evening. I think it works well.*
>
> 03, Family Member

Increased phone and/or online video-link services provided valuable support to clients during the pandemic and enhanced flexibility to engage when they needed to.

> *[Voluntary organisation], that was my main source of support and especially during the COVID. I had been to the live meetings pre-COVID and then the online ones were a godsend 'cause there was weeks when I wouldn't attend one but there was weeks when I'd attend five. When it went online, then you had an option of five digital meetings that you could attend, whereas you only had the physical once a week. And like that was, for me a lot of the time, apart from a phone call to [family] or something like that, that would have been my only social interaction in a day. So yeah, without them, I don't think I'd be standing here in a sober state, speaking to yourself.*
>
> 10, Male Client, early 40s

While one client found phone calls from statutory key workers and professionals 'invasive' after a period of time **(08, Male Client, early 50s)**, others found regular phone check-in's supportive while waiting for services to become reinstated.

> *It was great sort of at the start because I didn't have to see my key worker once every [number of weeks] because of it all. It was all a phone call.*
>
> 08, Male Client, early 50s

> *They [statutory substance use service] got in touch with me [during the pandemic], had a wee chat with me on the phone now and again, referred me to [counselling service], they were very, very good.*
>
> 19, Female Client, early 40s

There was phone call check-ups by the key worker, but she was saying, 'Look I'm trying to arrange this for you but there's nothing we can really do right now especially because of the residential treatment things were all shut down and converted to COVID hospitals.' So like once those things started opening up again then the queue could start moving again, so that was mainly it. It wasn't that I felt fobbed off or anything like that.

10, Male Client, early 40s

Remote delivery also helped facilitate increased engagement from people with social anxiety, physical health issues, living in rural areas, caring responsibilities and parents with childcare and home-schooling responsibilities.

Lockdown helped those who really struggled to leave the house anyway. Actually they have engaged well because essentially their biggest problem, was part of what we were trying to do anyway, was get them out [...] It has allowed us to reach out to clients in a completely different way [...] For example, those guys in Fermanagh, whether it's us travelling to them or them travelling to us, it's long journeys, which are often unnecessary. So, technology has bridged gaps that were unbridgeable before, you've got that side of things.

ASCERT Adult Services

Some service users who have physical difficulties found Zoom counselling more accessible.

Dunlewey Addiction Service

So we were able to get grant funding and employ the services of Dunlewey [Addiction Service] to provide what were intended to be brief interventions with Stella Maris and Housing First clients and the flexibility that afforded with the Zoom calls and things. And especially the Housing First guys who didn't want to come to Stella to meet with them but to be able to have a call at six o'clock in the evening whereas in the past they may have been required to travel to Stella for half two in the afternoon, that flexibility was incredibly useful.

De Paul

I've noticed as well with some of my own clients who have children, maybe they're unwell, whereas in the past they would have had to cancel their session with me because they weren't able to make it up to Newry. But now, even though the wee one might be unwell, they could be sleeping on the sofa, or watching a wee cartoon, and my client can still proceed then with her one-to-one.

Davina's Ark

Subsequently, providers reported better engagement in group and individual sessions, higher retention and completion rates and lower DNA[59] rates with some clients.

Once established, remote delivery saved resources due to reduced travel time. It was also quicker organising phone contact and online video-link sessions in comparison to face-to-face delivery.

We also found for the outreach team, because we were covering quite a big geographic area, there was a lot of time spent travelling between calls. They just weren't able to see as many people, so we were starting to build a significant kind of waiting list. So, the waiting list kind of disappeared because we were able to work through people, see more people, get people on quicker. So, there was a certainly a benefit to that.

Simon Community

The time that has been saved as well through being able to hold meetings remotely has been extremely beneficial, I think, to everybody.

Davina's Ark

Organisations continuing to deliver services face-to-face also noted that redesigned and adapted services were benefitting programmes and resulting in higher completion rates. Clients who had engaged with these programmes during the pandemic also emphasised that adaptions were successful.

The numbers of people that actually finish has really increased because they're all coming in as one group of people over two days and they run right through to the end and then we start again [...] Just having the one cohesive group right through. Much more therapeutic, we get to know each other. Whereas before there would have been one or two admissions each week and one or two discharges each week. So, that's been a plus that we're going to try and hold on to.

Carlisle House and Gray's Court

I think [voluntary organisation] used to have an eight-week programme and they reduced it down to four-and-a-half-week, and so it was four and a half weeks [...] but they done really, really well and I made good progress.

11, Male Client, mid 50s

[59]Did Not Attend.

For those receiving statutory OST, provision of weekly medical prescriptions collected from pharmacies as opposed to key workers reduced travel time, costs and made them feel 'more normal' (04, male, early 50s) about being on the medication. Reduced visitations to pharmacies also helped some people avoid situations and people which may have led to drug use.

> *So because of the lockdown and to keep the people out of the chemists they put me on a weekly pick-up, which meant I wasn't going down to the town just, I wasn't bumping into people, dealers. I was staying at home a lot more, just out of sight, out of mind, I wasn't using. Now with relaxation of COVID restrictions, my use increased and I was back on daily pick-up. Going to the chemist shouldn't be every day or every couple of days, something wrong with that.*
>
> 04, Male Client, early 50s

6.4.2 New Services

Figure 57 reports that 60% of providers also identified the development of new services as a positive impact of the pandemic. Qualitative data revealed providers remained responsive to the changing environment created by the pandemic and developed new services in line with identified client needs.

Organisations reported a variety of new programmes including: new services for the 'hard to engage homeless population; increased peer support' (Simon Community); online cookery, fitness, hairdressing, counselling sessions; 'brief interventions' (De Paul); and 'food vouchers' (Extern). Some providers also increased use of interactive multi-media methods to engage with different client groups.

> *As a result of all these things that were then being brought to our attention, we started to then run things like cooking classes. One of our service users on Zoom started to do like a cooking class every week for the service users, very basic things [...] One of our service users is actually a hairdresser, so she did Zoom classes as well for some of our service users about wee tips and so on. Another one of our service users did gardening tips [...] and then one of the gentlemen that we have in recovery did exercise class once a week too. So, really that all came about because we identified the needs with regard to people's physical and mental wellbeing.*
>
> Davina's Ark

> *We are being much more interactive with our clients. So, we're getting them to link in say, for example, around self-help stuff, meditation, mindfulness, and you can link them into YouTube or whatever else it is, it's promoting another type of awareness.*
>
> ASCERT Adult Services

> *We had to look at other diversionary ways to help them [young people] cope. A lot of it would have been worksheets, reading, like TED talks, all the things they would have access to without having costings either 'cause a lot of them have connection to Wi-Fi, but they've never no money on their phone, so, we were really trying to make it work.*
>
> ASCERT Youth Services

Another organisation noted the development of new services and training in response to increased occurrence of injecting-related harms.

> *The work the teams did with supporting people to access treatment for hepatitis and delivering that kinda outreach; chasing service users around the city centre to give them their medication. That wasn't necessarily the result of coronavirus but did happen within that time, and has indicated that in the future that's a much more obvious way to go in trying to bring the numbers of that diagnosis down or at least to manage them and stop them getting any bigger and also to provide people with treatment.*
>
> Extern

6.4.3 New Clients

Figure 57 highlights that most providers (60%) identified new clients accessing services as a positive impact of the pandemic. Some new clients typically used drugs socially or recreationally and did not engage with services as frequently as those experiencing problematic substance use. However, increased drug use due to working from home, being furloughed, losing employment, isolation, having more time to reflect on their drug use or 'family members noticing' their drug use (Simon Community) and/or other adverse health and social impacts as outlined in Section 4 resulted in more people accessing services for help.

> *We definitely saw an increase in a different kind of demographic because we either had that younger population of people who were through the care system, through the prison system, in and out of homelessness, kind of that traditional, almost stereotypical group. And then we had an older population, some of them retired, some of them, still in work but kind of struggling. Now we had people who, kind of in their 30s, maybe 40s, who were furloughed or had lost work but were coming forward. We wouldn't necessarily have had that population before, and again predominantly alcohol-related.*
>
> Simon Community

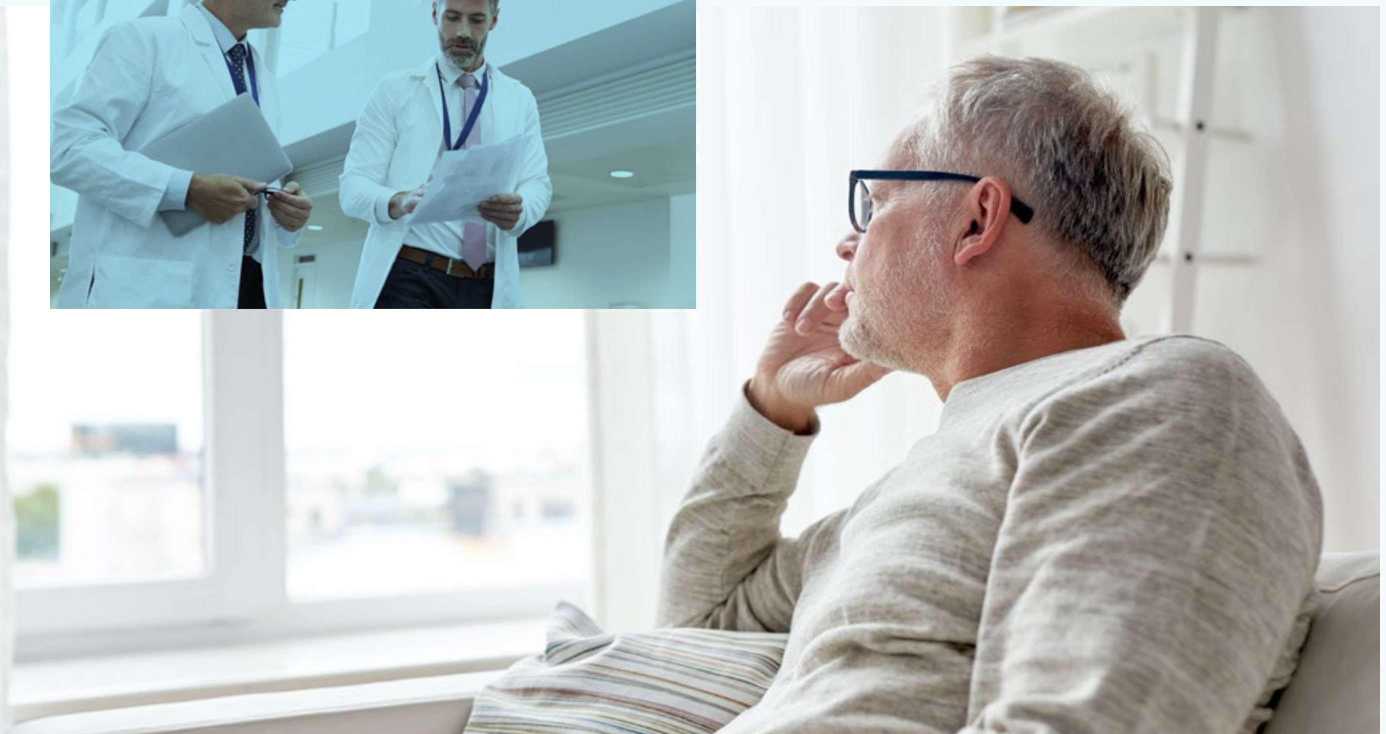
> *We had a huge number of calls at the early stages of people who had used like socially before and then suddenly were starting to use an awful lot more just because of isolation again.*
>
> Carlisle House and Gray's Court

Increased numbers of very young clients aged 12 to 14 years old was also noted by one youth organisation as worrying and linked with COVID-19 impacts on mental health.

> *Mental health is going to have a major impact and we're actually starting to see it already now. So, normally within the DAISY service itself, the young people that are coming in, our age range is normally 11 to 25 [years] but our clients are normally around 16, 17 [years] and above, with the odd wee one or two coming through. Within the last two weeks, we have had eight referrals of 12 to 14 year olds.*
>
> ASCERT Youth Services

Remote delivery of programmes also enhanced accessibility for people living in rural locations resulting in greater uptake of services.

> *So although we're based in Newry, through COVID, we found that due to being able to Zoom and other additional methods, we're able to extend and reach so many more people now throughout the North. And we also would have a number of service users as well who are from the southern counties too.*
>
> Davina's Ark



Organisations providing family programmes also noted increased service use. Heightened demand was linked to COVID-19 restrictions exacerbating family conflict over drug use and increased hidden harm cases[60]. Remote delivery appeared to very efficient for this client group particularly in rural areas.

I actually think with the way COVID has been, it has actually given us that opportunity to link so many more parents in together, because sometimes, you'll have a few in the Western Trust, some in the Northern, some in the East. And actually it's been really lovely, actually, to bring families together throughout which is really nice.

ASCERT Youth Services

Family members and relevant clients emphasised that individual, group and family therapy services they had remotely engaged with during the pandemic were a vital source of support and helped to resolve family conflict.

We [teenager and parent] were having small arguments every day and then, if we did have a big argument, I'd overthink about it and still think she was in a bad mood with me continuously, if you know what I mean. And then [counsellor's name] came and we talked about it and then her and [parent] talked and then me, her and [parent] talked and we haven't argued that much since.

02, Male Client, teenager

What's really worked well is the family therapy. Both of us working together, and we done it over like a video chat [...] It was me, my [child] sat like this here, and we sat for over an hour once a week, and we got a lot said and done. [Child] would say [child's] piece, I would say my piece. There was a lot of emotion [...] This joint thing was the best thing. I mean if we hadn't of got that I don't know where I would be to be honest.

01, Family Member

6.4.4 Cooperation between Service Providers

Figure 57 illustrates that two thirds (60%) of NIADA organisations identified cooperation between service providers as another positive impact of COVID-19. Qualitative data indicated effective inter-agency cooperation and coordination during the pandemic particularly within the voluntary and community sector and, to a lesser extent, with statutory services. However, most providers did emphasise they had 'some amazing partnerships with the statutory sector' (Start 360), while one emphasised they were 'heavily reliant on support from the community and voluntary sector' (ARC Fitness).

Despite some previously discussed frustrations with statutory services, there appeared to be effective working relationships with most participating NIADA organisations. Some organisations also reported decreased competitiveness between providers to meet client needs during the pandemic.

Tasking meetings were consistent right throughout that whole process which is a really important part of service provision for the service users and for those in the city centre; businesses and so on. So, there was quite a lot of stuff that was really good, really proper multi agency partnership working for the benefit of service users that are, cause I'm sure you're aware, there's a lot of politics and argy bargy about service provision seemingly in Belfast and that I think was put to one side largely because again why would it not be anyway regardless of coronavirus? But that seemed to dissipate somewhat and people seem to be much more able to respond to service user need [...] We've fostered much closer working with other agencies and I think the statutory agencies and statutory partners had much more understanding of voluntary agency work.

Extern

[60]See Section 4.4.

6.4.5 Support and Funding

NIADA organisations were asked if they had received any of the below supports since the beginning of the COVID-19 pandemic.

Figure 58: Supports received by NIADA organisations

Figure 58 reports that all providers who answered the question received public health guidance, access to information and PPE. A lesser number of services (55%) reported communication with statutory organisations and just under half (44%) stated support from local service collaboration. Qualitative survey data identified additional support from the 'Infection Control Unit BHSCT, COVID19 Testing Belfast Trust RQIA, residential guidance [and the] National Testing Programme' (Carlisle House and Gray's Court).

Other qualitative data refers to increased funding for relevant organisations from the Public Health Agency, Department of Communities, Housing Executive and Supporting People during the pandemic. This investment aided the implementation of infection control measures and move to remote delivery or adaptions of services. It also provided resources to target people most in need while allowing services to remain adaptable, reflexive and responsive to emergent needs.

On our side we were really lucky in that our funders, which are primarily the PHA [Public Health Agency], the Housing Executives stuff like that, those big, big organisations were able to respond quite quickly with additional pots of money once they became available to them. So, in some senses we were able to work through it [the pandemic] the best and make some positive changes in relation to supporting service users.

Extern

Certainly, last year all the services were oversubscribed throughout, there was more people looking for them. We got funding, extra funding, for example PHA, in order to meet the demand.

ASCERT Adult Services

Our funder was flexible as well, and they listened to us. The services that I talked about are all public health-funded and our public health leads were amazing, they listened to what you needed. They constantly checked in with you, they were talking to us about our services, what could they do, what could we change, and you really felt you had the opportunity to really shape and inform how things moved forward within that COVID time.

Start 360.

6.5 Going Forward

The final findings section presents participants views on issues affecting the restoration of services and subsequent recommendations for future service delivery. Discussion focuses on interagency cooperation and coordination, blended hybrid model, continued investment and development, tacking stigma and wider drug policy reform.

NIADA organisations were asked to reflect on the extent to which the below issues represented challenges to restoring services.

Figure 59: Challenges to Restoring Services

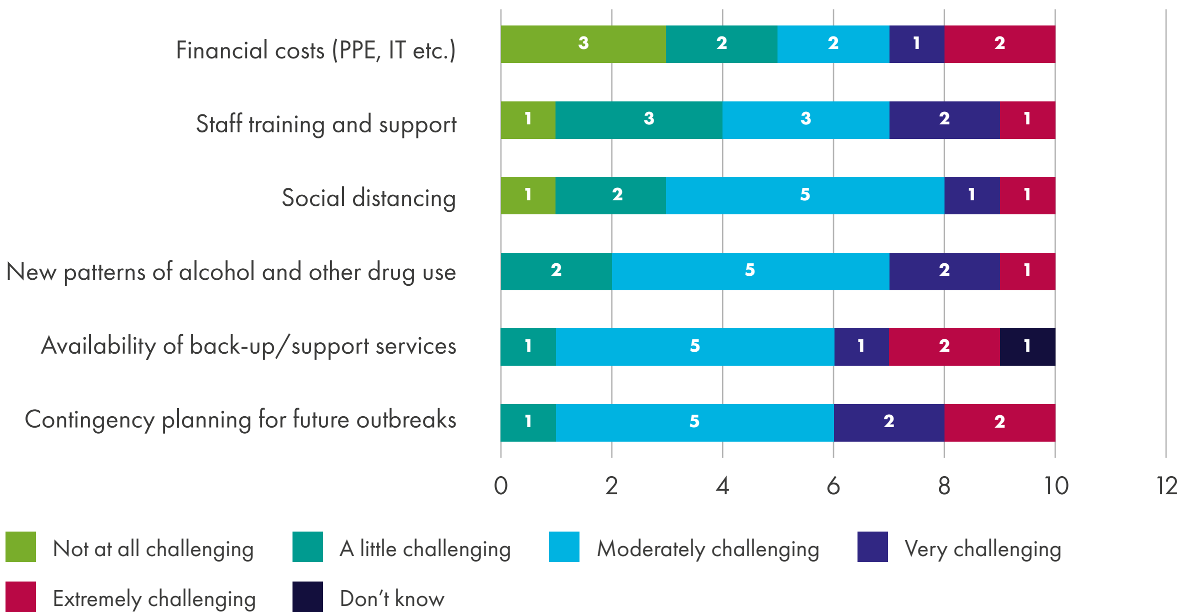


Figure 59 reports that most organisations (70%) rated financial costs associated with restoring services as challenging. The majority (90%) also rated staff training and support and social distancing challenging. All providers identified challenges with new patterns of substance use and availability of back-up/support services.

Contingency planning for future outbreaks was the top rated challenge identified by all providers, with 40% stating this was very or extremely challenging to restoring services. Qualitative data throughout this section expands on these factors and other important issues for consideration going forward.

6.5.1 Interagency Cooperation and Coordination

All providers emphasised the need for continued and improved cooperation and coordination of services across the voluntary, community and statutory sectors to meet client's needs. While collaborative partnerships and referral routes had been established, the need to continue the good practice evident during the pandemic was highlighted. Some providers maintained that voluntary and community services were sometimes undermined by statutory providers and competitiveness between organisations. However, partnerships between all sectors and departments were deemed essential to mitigate the longer term adverse impacts of COVID-19 on people who use/used substances, their families and the strain this will place on services across all sectors.

> *Partnerships are hard work, but if you invest in them, they work, so we do need the statutory [...] I think it's about our sector being realised as the professional sector that it is. We're not doing a Mickey Mouse job here, we're professional people, well-supported, following policy and procedure, doing solid work and we need to be recognised for that. But it is about partnership and it's about recognition about what we all bring to the table, and it's about cutting this whole ethos where, 'Oh, I can't tell them because they're in competition with me.' That all needs to go as well, that all needs to kind of stop. It's about just working together better.*
>
> Start 360

Many providers, clients and family members reported the need for a one point of referral system for all clients throughout the HSCTs areas to improve service accessibility, avoid unnecessary delays, reduce waiting times and avoid reassessment when clients moved to a different HSCT.

> *I would like to change the bordering off of services. Like coming from [placename] to [placename], I know that there's services in [placename] that would be of use to the people of [placename] and vice versa and they can't really link up because they're not in the same Trust. And that's just rather complicated politics but it's just politics like.*
>
> 16, Male Client, early 40s

Three organisations stated that discussions about establishing a one point of referral were currently taking place in the WHSCT:

> *In the west services, they're working with the Trusts at the minute around the same issue referral pathway and [De Paul and Dunlewey Addiction Services] are probably involved in that as well. And that would be amazing, where we have one referral system, you can take it anywhere you need to go without having to come to us, having to go there.*
>
> Start 360

> *And having to answer the same question to fifty different strangers and all of that.*
>
> De Paul

6.5.2 Blended, Hybrid Model

Given the previously discussed positive impacts of remote delivery[61] and other adaptions of programmes, most participants believed a flexible, blended, hybrid model of service delivery should be adopted going forward but with most wanting a return to some face-to-face services.

> *We can see now that hybrid working is the way forward, partly because you don't want to drag someone 20 or 30 miles for an appointment every single week, neither us or them [...] But also then you can give people choice, clients choice themselves and that's slightly more autonomy as well, and while you're obviously trying to get them to come out in order to reconnect with the world, it's still also allowing them to reconnect with the world using other mediums. So, I think it's got to be integrated into services going forward and we'll be looking at a hybrid approach anyway and that would be how we would sell the service going forward.*
>
> ASCERT Adult Services

> *A lot of our service users are very in favour of a blended approach, using the remote working like Zoom and so on some weeks and then starting to come in face-to-face the following week.*
>
> Davina's Ark

> *I think that a good thing that's come out of the whole COVID thing is that services are being delivered now the way the client wants them, or the service user wants them, as opposed to the service.*
>
> Dunlewey Addiction Service

[61] See Sections 6.3.2 and 6.3.3.

I think any process is better face-to-face. But I know there's people that would also prefer to be able to sit at home and speak to somebody and get over social anxieties and other anxieties. So, I think if something could come from it [impact of COVID-19 on service delivery], I think the malleability of people in services to suit the mobility needs or the mental health needs of people, what has been focused on and has been looked at during the pandemic and I see no reason why that should discontinue.

16, Male Client, early 40s

Adopting a flexible, hybrid model of delivery would also mitigate limitations and substantial costs of appointment-based services in the voluntary, community and statutory sector given associated high DNA rates.

[Voluntary organisation's] first appointment DNA rate was 50% [before COVID-19], you think about the amount of time that was wasted.

Dunlewey Addiction Service

Services that are based on appointments and where people don't attend, surely we must overhaul that. That must waste an absolute mountain of money and I'm not saying those services don't have their place, they do. But if we're going to manage service user deaths as a result of suicide, substance or alcohol use, or dependence, or overdose, and try and protect the future of those clients and minimise the ambivalence that some of them have towards their own lives, we need to be really, really, inclusive and we need to be really careful about how we think about what's going to work and what does work and we know that the current system doesn't work.

Extern

Overall, while there was a consensus among providers for a blended approach going forward, there were also calls for a review of what programmes and modes of delivery were most effective and where more development was needed.

That's one of the things is how do we get back to a face-to-face system? It would slow down things. So, I'm curious about how we would work and maintain the present level of delivery that we are delivering that we are doing, how we do that? [...] Can we do it [face-to-face] for people who really need it and how do we assess that and how do we assess that need? And is there a better way of using these technologies even for clients? Is there something also that we could be doing that would encourage people to use those technologies? Is there something else we could be doing to roll things out or connecting with other providers?

ASCERT Adult Services

I think it is really critically important from now on in that we review, and I don't mean that in a formal review lengthy process, I think it's critical that we review the services we have and how effectively they need to be on a continuum.

Extern

In terms of staffing this model, some providers highlighted that financial investment was essential to avoid 'staff shortages' (Davina's Ark) and ensure appropriate staff training in substance use and remote service delivery.

We need to be looking at how do we create a workforce that's geared up to drug and alcohol support for people? Because most of the time we're bringing in generic practitioners [...] How do we prepare a new workforce? I think there's a need for that upskilling an awful lot as well, so whenever people come into these places, they are already at a good standard.

ASCERT Adult Services

6.5.3 Continued Investment and Development of Services

A strong theme was the need for continued investment and development of health and social care services for people who use/d drugs going forward. Qualitative data identified a number of areas which are discussed below.

6.5.3.1 Political and Organisational Investment

Political and organisational investment and collaboration was deemed essential to meet clients' immediate and continuing needs. There was a view among some participants that drug use issues were not treated seriously enough by politicians. The lack of political will and investment has been recently highlighted as extremely concerning in a report by the Public Accounts Committee in Northern Ireland (PAC, 2022) particularly in the context of increasing levels of drug-related harm in the region.

> *I've contacted local MLAs and counsellors and stuff and I don't think they really want to believe there is as big a problem as there is. I know this is a rant. But, when you don't believe that there is a drug problem, then you're not helping anybody. It's really kind of like we need recognition and investment, really, that there is an issue.*
>
> 03, Family Member

Participants maintained that continued and consistent financial investment would aid the development and operation of meaningful, joined-up and targeted services across departments mitigating longer term impacts of the pandemic.

> *Departments need to speak to each other. Departments to not be siloed because it costs so much money and so much of a waste of resources and for what a lot of those services are delivered, we could deliver it in the voluntary sector for a fraction of the cost and with much more effectiveness [...] There's enough work for everybody, both within the statutory sector and voluntary sector, and it's about us all doing what we do best and meaning that a service user can enter service A statutory or voluntary or community or private or whatever tier and they can go through whichever way they need to go through to get what they need.*
>
> Extern

> *We do need more services but again you can't just throw money at things and expect them to get better. It has to be meaningful.*
>
> Regional Service User Network

It is worth noting that the PAC (2022) concluded that financial investment is crucial to the implementation of the new drug strategy in Northern Ireland.

6.5.3.2 Tackle Poverty and Socio-Economic Deprivation

Participants believed investment was needed to tackle poverty and socio-economic deprivation given the impacts of COVID-19 and the strong association with problematic substance use, mental health and drug-related harms. As previously discussed, the most adverse impacts of COVID-19[62] were often experienced by people experiencing elevated levels of socio-economic inequalities and stigma. Tackling poverty is also crucial given that most alcohol and drug-related deaths occur within jurisdictions experiencing high levels of socio-economic deprivation (NISRA, 2022a,b,c, 2021). The longer term impacts of the pandemic and current rising cost of living will also potentially exacerbate these inequalities and subsequent drug-related harms among these client groups and others (British Academy, 2021). While recognising the complexities of addressing these issues, participants strongly supported the need for change and planning in this area going forward.

> *The impact of poverty and deprivation and the role that that plays. That's a huge thing to try and change, but it does play a massive role in the issues that we see presenting to all our organisations and needs addressed.*
>
> Start 360

> *I think it'll be interesting to see coming out the other end of it hopefully how if in any way those sorts of structural oppressors are addressed and the answer is I don't think they will be. I don't think they will be in the short-term which I don't think is right. So I think there is people who have unequal access to services and accessibility is the key to it all.*
>
> Extern

6.5.3.4 Establish Meaningful Involvement of People Who Use/d Services

Another key element to service development going forward was establishing meaningful involvement of people who use/d services into service design, delivery and policy. Most interviewed clients were engaged with a peer service either within NIADA or externally and strongly supported this development. Clear preferences were given to services involving peers with shared drug use experiences and subsequent mutual support gained through peer-led support services.

[62] See Section 4.

Originally the facilitator [of a voluntary peer group] was basically a fellow that had been through the wringer himself and everything, and the people involved had their own issues. And because of that, there was what I refer to as a 'no bullshit' attitude in the meetings, where if somebody started warbling on about something that other people wouldn't be aware of, they'd pull them and say, 'Would you ever shut up, you're talking shit here, man.' You know, you might be an academically gifted, highly qualified counsellor but you're speaking to people that have been here, done the same [...] And also with the context of people that would be, in my case, say 20 years older than me but also 20 years younger than me too and then people of the same age so they'd be of a similar peer group or something like that. And that gave me a lot of things I've learned. But then, every now and again, I would pipe up and pass something on too and, hopefully, some people gained and some people said they did [...] Like they definitely did me a world of good, like that's me anyway, but I'd be very surprised if there's any negativity directly towards it.

10, Male Client, early 40s

For me, a lot of these people [in services] have university degrees or read about addiction but they have never experienced being an addict. So, they don't understand what's going on with your addiction. You need to have been addict to understand an addict [...] I think we need more addicts in services as they know what they are talking about. They have been there. They know the guilt and shame. They know what works. So, more people who have been there in services.

06, Female Client, mid 40s

While involvement of people who use/d services was evident within certain services, providers believed that further development and meaningful involvement in co-produced service design and delivery should be embedded in services.

In RSUN [Regional Service User Network], we're kind of working towards setting up agreements and with people engaging with their service users. What do you want? What do we want? How can we bring this together? Otherwise it's just rolling out the monkeys, that's what I call it, 'Hey, look here's all our addicts.'

Regional Service User Network

People talk all the time about service user involvement, and the importance of it. But it's only important if it's really, really real and has a real focus, a real purpose [...] If you're going to use service users and give them a voice, you have to support them, you have to develop them, and you have to do it. Because otherwise you're using them, you're doing exactly what society does on them.

Start 360

Those words 'co-production, co-delivery' and everyone flies off these words but in practice, it doesn't happen [...] That's probably the big change that needs to be integrated, needs to become concrete, become embedded in services.

Carlisle House and Gray's Court

6.5.3.5 Embed Hidden Harm into More Programmes

Providers working with children and young people emphasised the need to further embed 'hidden harm' (ASCERT Youth Services) into programmes especially as the pandemic had escalated this issue for some families[63]. Increased focus on identifying and tackling this issue would ensure that children and young people affected by increased problematic substance use among parents during the pandemic would receive help and support.

6.5.3.6 Expand Family Services and One to One Support

The pandemic had also resulted in more family members approaching services for help due to escalation of their children's drug use and/or increased visibility due to pandemic restrictions[64]. Continuing to develop and deliver support to families, particularly in more rural areas, was crucially important to mitigate potential harms of problematic substance use on family relationships. Family members specifically emphasised that more one-to-one support and counselling would be beneficial.

I found it really tough to find any family support services probably because of the rural area I live in. It was something I was looking for, but I found it tough to locate them. So, perhaps more accessibility and more knowledge and info about where they are would help.

03, Family Member

I wouldn't mind a bit of one-on-one support. I haven't been offered that yet [...] It's overwhelming for a parent. It's like you're doing all this for your [child], you're doing all this for your family. But, where's the help for you? [...] I need support. Parents need support. We're doing all this support, we need support too [...] Somebody for us to speak to on a one-to-one basis without having to be on a waiting list for god knows how long, or having to pay for it yourself if you want to speed it up a wee bit [...] I would love to be able to get somebody that I can speak to, yep. That'd be great. Even if it's a Zoom call, it doesn't have to be in person. Just a Zoom chat, that would be great.

01, Family Member

[63] See Section 4.4.
[64] See Sections 4.4, 6.3.5 and 6.4.3.

6.5.3.7 Increase Education and Diversionary Activities for Young People

Participants emphasised the need for more education and diversionary activities for young people to tackle boredom, prevent substance use and/or the escalation of substance or polydrug use and related harms. Increased activities would also help counteract 'Xbox disconnection' (ASCERT Youth Services) which became a prominent issue during the pandemic due to social distancing and remote learning. As well as more prevention and harm reduction initiatives being 'integrated into the education system' (Davina's Ark), a number of diversionary activities were suggested. These included increased numbers of secular 'youth clubs' (Carlisle House and Gray's Court), community groups and sporting activities. Provision of these services was limited or absent in some rural locations of Northern Ireland.

> *Sporting things like boxing, MMA [mixed martial arts], things like that would be good. Some of the young people we work with come from rural communities so there isn't really access to a lot of services like that. So, alternatives, to using cannabis or hanging about the streets are very, very limited to get involved with. If there was something more like that about it would be great.*
>
> Start 360

> *I do think, generally, in this rural area that I live in [place in NI], I do wonder, could there be more intervention here? [...] There's so many lives here that are being ruined with alcohol and drugs, and there's nowhere really that, if you felt on a day that you wanted to make a change, well you'd have to go to [place in NI] [...] Even if they could spread out cause I know there's other services across Northern Ireland and they do spread out, and you can access them you but do people know how to access them?*
>
> 03, Family Member

6.5.3.8 Improve OST Accessibility and Provision

OST provision and waiting lists were also highlighted by qualitative data as an area for improvement. It was believed that the appointment-based, medical model informing OST and other statutory services inhibited service effectiveness and accessibility for specific populations, especially within the homeless community and those experiencing problematic substance use. The issue was exacerbated during the pandemic due to temporary suspension of the service which increased waiting times.

> *I think the consultant led medical model that we have around addictions and mental health has its place, but for our cohort of clients [homeless community] [...] those service users need access to support. It needs to be brought to them. It's not going to be a case of them going and getting it. It's just not. It's not reality. They need access to SPT [substitute prescribing team] within the same day they need a consistent holistic sustained support.*
>
> Extern

The strict routines and regulations of OST constrained some people's ability to work or engage with education programmes as part of their recovery process. Resentment and frustration with reprimands for missing prescriptions and/or occasional use of substances were emphasised. While regulations are important from a risk management perspective given the controlled nature of substitute medications and potential risk of overdose, OST clients and some providers believed a more flexible, accessible and accommodating approach should be adopted going forward. Adopting this approach would also help mitigate the previously discussed increases in drug-related deaths, overdose and injecting-related harm.[65]

> *There was a couple of days I missed picking up in the chemist because I wasn't able to get there and then I lost a script as a result of not being able to get there. I missed the [day] because I was working and then I was late [...] So, I had to go back down to [statutory drug treatment], they were good enough that time because I had a valid excuse, they put me back on the script straightaway, I still had to go back down to [low dose] and then up again. They were a wee bit accommodating but I had to basically ask them, just beg them to reduce my days at the chemist to fit in work [...] You're afraid of losing your script because it means you're back to square one, you're afraid of slipping up because you're back to square one. There definitely needs to be less punitive measures, they have to be more understanding about the nature of the beast like. People have slips. If you're having trouble with COVID and you're using as a result, you're getting punished, this isn't gonna help. And then they tell you, when you're starting, they tell you like it's all about harm reduction. But once you start, then it's all about abstinence, so they need to stop lying to people as well, tell them it's about abstinence before they start, see if they still want to engage.*
>
> 04, Male Client, early 50s

[65]See Sections 4.6.2 and 5.3.5.

6.5.3.9 Improve In-Patient Detox and Rehabilitation Accessibility and Provision

Another key area for development was the accessibility and need for more in-patient detox and rehabilitation services for young people and adults. Other reports in Northern Ireland have also recently highlighted that access to residential detox and rehabilitation is inconsistent and needs reviewed as two HSCTs do not have formal access to detox beds (PAF, 2022; NIAO, 2020b). Increased numbers of people presenting for help due to adverse impacts of the pandemic had increased demand for these services. Temporary suspension of statutory in-patient detox and rehabilitation services during the pandemic increased pressure on an already strained service and further increased waiting times.

> *There is a huge need for Tier 4b residential rehab treatment services. We have been inundated with requests for help.*
>
> Carlisle House and Gray's Court

> *I'm absolutely flabbergasted that [place in NI] hasn't got a detox centre. I mean that. A detox centre is it's the core of treatment. Everything else that follows on, follows on from that. The detox is getting over the physical part of it and then the psychological part then is dealt through the various different organisations. Without them coming to some kind of terms with the detox, you're talking to the brick wall. Nothing's going to get through. It's unbelievable in this day and age that a city the size of [place in NI] hasn't got one.*
>
> 12, Male Client, mid 50s

6.5.3.10 Develop and Implement More Aftercare Programmes and Support

Providers and clients stressed the need for continued support after completing treatment programmes or engaging with OST. The need for 'aftercare and recovery programmes' (Simon Community), continued 'physical and mental health support' (ARC Fitness), 'social support and integration' (Regional Service User Network) were strongly emphasised.

> *There's no real work that comes alongside it [OST], there's no real counselling, there's no counselling, apart from like 'How are you? How're you getting on?' That kind of thing.*
>
> 16, Male Client, early 40s

> *What I would say is how they could improve is to have a little bit more emphasis on follow-up [after residential treatment]. The follow-up calls once a week were not sufficient, absolutely one hundred per cent not sufficient. I think there needed to be some more involvement.*
>
> 11, Male Client, mid 50s

6.5.3.11 Develop and Implement Dual Diagnosis Services

Previous findings highlighted the strong adverse impact of the pandemic on clients mental health[66]. However, there are very limited dual diagnosis services available in Northern Ireland to deal with the combined issue of substance use and mental health. There were concerns that longer term pandemic impacts would exacerbate dual diagnosis presentations further.

> *During this 18-plus months of isolation, if the world had mental health and drug use problems before, after that, isolation, all aspects are to going to be overwhelmed. Agencies are basically going to be overwhelmed because like, COVID's done a lot of weird things to people. But yeah, I say this is the tip of the iceberg. We'll be seeing the effect of this lockdown, I would say, for at least the next decade.*
>
> 10, Male Client, early 40s

It was firmly believed that statutory services needed to adapt and develop specific services to meet this immediate and continuing need. The necessity for developing accommodating, inclusive and accessible statutory dual diagnosis services working collaboratively with other substance use services was clearly emphasised.

> *You'll have a young person who's been referred to mental health, they're working with you and they're doing great, and they're referred to mental health, but it's taking that long to get into mental health they've probably relapsed quite a few times and they're not great. Then mental health are like 'They need to address their alcohol use before they get into mental health.' And it's just one vicious cycle. Then you have that whole like jumping from Trust area to Trust area. So they might be living in Belfast one minute, but actually they're living in Newtownabbey the next, or Antrim, so it's two completely different Trust areas, so the process has to start all over again with referrals [...] A lot of the time we end up being a holding service till [clients] try and get into [statutory] mental health services. That has been the case for such a long time and I think it frustrates us too [...] I really do feel that there needs to be the mental health support in place, alongside the addiction or any support there.*
>
> ASCERT Youth Services

> *There's a need for a better connection with mental health, the two [substance use and mental health] have been sitting as two separate units and so we know people can bounce back and forth between the two. We're having to handle the whole lot so there's a whole upskilling required for drugs and alcohol services, that brings on people's knowledge of mental health.*
>
> ASCERT Adult Services

> *There is the whole dual diagnosis issue and having statutory services that don't keep pushing somebody away, saying, 'No, I can't address your mental health because you've got an addiction.' And then addiction services saying, 'I can't address your addiction because you've clearly got mental health issues.' We need services that suit people not people that suit services, that's absolute nonsense and unfortunately has continued to be the driver behind statutory services, whether it be a children's social worker or adult disability team or mental health or addiction, it's always about you must suit the service, which is, sorry to say it, bullshit.*
>
> De Paul

6.5.4 Tackling Stigma

A challenge going forward is tackling the stigmatisation of people who use/d substances. Clients most adversely affected by the pandemic tended to be the most marginalised and stigmatised, including people from the homeless community and/or injecting drugs and/or were substance dependent. These people encounter internal and external stigma from family members, the general public, media, politicians and some health and social care professionals.

> *I'd love to see a change in the way that things are reported. I think that the language that's used isn't acceptable, where derogatory words are allowed to be used by politicians, by the media reporting on these politicians and by the media themselves, and that needs to change.*
>
> 16, Male Client, early 40s

[66]See Section 4.2.

A complete change in attitude is needed, this stretches right across, it's not just substance use or dependency, it goes right across even into people's attitude towards other people, that needs to change, Julie. People need to stop judging other people on their addictions, or whatever it is that they perceive that this person is doing wrong. Having an addiction is seen as a moral dilemma, it shouldn't be, it's not moral, it's physical. I'm physically dependent on [substance], first of all. Second of all, I didn't choose to do this, it wasn't for me, it wasn't a choice, a matter of morals or picking to become this way, it was just the way that I was made, so that needs to change. But that goes right across Julie. We're talking about stopping using words like 'scumbag', 'junkie', you know, all that needs to stop, 'alkie', 'They're different to us.' It all needs to change.

19, Female Client, early 40s

I still think there needs to be a lot of work done with educating society about the stigma of addiction. Like I've seen it myself through both my [relatives], my [relative] more so. And it's like you've got a big sticker slapped on your forehead. And I think there needs to be something done about that because this stigma of addiction is bullshit because there's addiction all around people.

10, Male Client, early 40s

People then are afraid to tell their doctor about their drug use and then there's some other ailment like, they're not getting proper diagnosis, they're not getting proper treatment. But then if you do tell them, the hospitals, that you're a drug user, but the way they treat you, they treat you differently like, 'You're a drug user. It's your own fault really.' They leave you sitting there, treat other people with cut fingers and all first.

04, Male Client, early 50s

Importantly, as the new drug strategy in Northern Ireland recognises, internal and external stigma can create barriers to accessing treatment and other services (DOH, 2021a). Addressing stigma will help improve service accessibility and uptake. To address some aspects of stigma, participants suggested public awareness and education campaigns surrounding substance use and people who use/used substances. Some organisations were actively involved in creating these campaigns to help mitigate stigma and discrimination.

The public campaign has taken up a lot of our time recently in the past few months [...] it's helping address the stigma, anybody with a dependency upon a substance makes you a bad person in a lot of peoples' eyes [...] So, we wanted to raise public awareness about an addiction or a dependency on a substance [...] There are these deep-rooted issues that need to be addressed and I think it helped, the fact that a lot of people would have increased their own substance use during the pandemic as well. I'm not talking about people who have problematic issues, just in general, maybe people drinking more wine during the week. And we were able to use that for our public campaign. That's what we based our public campaign on. The fact that you're drinking a little bit extra, it doesn't mean you're 'alcoholic', but have a wee look and see and there's help available out there if you need it. So, in terms of the positive things coming out of the pandemic, yes, that was huge for us now thinking about it. That awareness.

Regional Service User Network

Another proposed strategy for addressing stigma was to ensure adequate training on substance use and associated issues among health and social care services. This training would include moving away from a purely medical model to the social and environmental model. The social and environmental model includes important consideration of the relationship between trauma and other social issues with problematic substance use and can support a shift away from the moralism and individual responsibility surrounding substance use. It was recommended that a more person-centred, trauma-informed, strength-based approach was adopted going forward to meet clients' needs.

I think the statutory services tend to be stuck in kind of a more medical model [...] where they [clinicians] were the experts, they knew the answers, what to do, what the person should be doing. However, the person is the expert and it's a kind of a joint expertise, and they have more expertise about their own life. It doesn't matter how much you study or whatever and we would believe very firmly in that. And then also coupled with that is a strength-based programme rather than saying, 'There's something wrong with you.' We would say, 'What's happening in your life?' So not an expectation of what's wrong, but what's happening and Gabor Mate would talk about being trauma-informed, that addiction is just a symptom of other things. It's a coping mechanism, it's actually a really good solution at times. I think the voluntary, community sector, independent sector is moving quicker to a more strength-based model.

Carlisle House and Gray's Court

6.5.5 Drug Policy Reform

Interlinked with strategies to reduce stigma and other drug-related harms, some providers, family members and clients emphasised the need for wider drug policy reform in Northern Ireland. As previously mentioned, drugs such as cannabis and cocaine were becoming increasingly normalised in Northern Ireland and these participants believed the current prohibition of drugs should be replaced with either decriminalisation or legalisation. Benefits of adopting wider drug policy reform included: avoiding the impacts of criminalisation affecting future life opportunities; reducing drug-related harms; providing extra resources for substance use treatment and support services; and disrupting organised crime groups involved in the drug markets.

> *Well, decriminalisation and legalisation is the only way they're ever gonna win the war on drugs like. They're just creating a generation of criminals as a result of it. Once you get a drugs conviction, you've nothing to lose then, you've already got the conviction. It affects you getting jobs, you have trouble with work, so it affects the choices that you're gonna make from thereon in. People are going to use drugs, if they're going to use them they're going to do it anyway whether it's legal or illegal.*
>
> 04, Male Client, early 50s

> *Criminalisation for the likes of cannabis or something like that, people getting arrested, isn't right. I've never had any trouble with the law but I'm super-cautious. But, youngsters getting into trouble for a wee £20 bag or something like that? There's always going to be drugs the way there's always going to be prostitution as well, that's just the way of the world, there's always going to be corruption as well. I'd say liberalise, legalise cannabis, it'll also cause problems for the organised syndicates controlling them, the distribution, they'll move on elsewhere.*
>
> 10, Male Client, early 40s

> *I'm speaking more personally than on behalf of DePaul but it speaks to the values of our organisation anyway and it is around substance use and mental health and physical health and the whole spectrum of wellbeing and that is my long-term dream that substance use is decriminalised because it is the one way that it will truly address people's needs. If you need any example of the success of that, look at the Portuguese model and certainly the significant and swift changes that came about because you will not be deemed as a criminal for taking the illegal equivalent of a pint or a cocktail because. Let's face it, it's just horses for courses, what's your poison, do you know? Alcohol's as dangerous, well, according to the World Health Organisation, by a fine margin, just comes second to heroin in terms of risky substances in the world. So it's a nonsense and it needs to be decriminalised in order to make real progress.*
>
> De Paul

> *I think there has to be a complete and utter look at drugs themselves and the so-called drugs war, because it hasn't worked and there's another way of looking at how, because people are using cannabis like their sweeties and you're not going to reverse that. It has to be another way of managing that so you're supporting people to change and also helping them at the same time rather than stigmatising them. And we know ourselves like, needle exchanges and all that have worked. They haven't created more 'junkies', as some people worry about, they've actually made it safer for people [...] But also that if there's regulation and recognition of that, then there's funding towards it, and to keep people safer. Because if you look at it, they're going to do it anyway, so you might as well keep people safe while they're doing it.*
>
> ASCERT Adult Services

7. Conclusions and Recommendations

The aim of this study was to provide an updated and detailed understanding of the ongoing impacts of the COVID-19 pandemic on people who use/d drugs, family members and NIADA service providers in the voluntary and community sector. Specifically, the report has examined impacts on: adverse health and social issues; sources of support for clients and family members; drug markets; patterns of drug use and related behaviours; and service delivery. The mixed methods design used multiple data sources and captured the perspectives and experiences of people who use/d drugs, family members and service providers to generate an in-depth understanding of these issues. Key findings, long-term and short-term recommendations are now discussed.

7.1 Health and Social Impacts

Several adverse health and social impacts of the pandemic on people who use/d drugs and their families were identified. The wide range of psychological, physical, social and economic harms clearly evidence the necessity for a co-ordinated, cross-departmental approach to meet the immediate and continuing needs of people who use/d drugs and their families. Addressing substance use treatment needs and tackling wider social, economic and health inequalities to mitigate the longer term impacts of the pandemic is crucial.

Findings discerned that the most adversely affected clients during the pandemic were people dependent on drugs and/or part of the homeless community and/or injected drugs. These people experienced elevated levels of social, economic and health inequalities prior to the pandemic. Their existing marginalised and stigmatised position was exacerbated due to the impacts of social distancing and infection control measures.

A major adverse impact of COVID-19 on people who use/d drugs was deteriorating mental health evidenced through high levels of anxiety, depression, social isolation, emergency presentations and constrained access to statutory mental health services. However, there is a lack of dual diagnosis services for young people and adults in Northern Ireland despite the international evidence-base surrounding the effectiveness of these provisions. The new drug use strategy stipulates that support for people with dual diagnosis will be reviewed, a new managed care network composed of experts in dual diagnosis will be created to ensure services are meeting needs and an integrated model between all tiers of substance use services and the Regional Trauma Network implemented (DOH, 2021a). However, the relative absence of substance use, dual diagnosis and the assertion that 'a dedicated dual diagnosis service is not the answer' in the new mental health strategy is concerning (DOH, 2021b: 72).

Northern Ireland is unique within the UK as it is a post-conflict society. It also has persistently high levels of economic and social deprivation, the highest rate of economic inactivity and the poorest social infrastructure (NISRA, 2021; Ballantine et al., 2021). It has the highest prevalence of mental health problems in the UK (DOH 2021b). Similar to substance use, mental health is influenced by social, economic and physical environments and inequalities. People on low income have higher rates of mental health conditions which can place them at risk of economic hardship. The legacy of the political conflict also has a significant impact on mental health and substance use. Deprivation and high rates of mental and physical health illness co-occur in areas most impacted by violence, a position relatively unchanged in the 25 years since the signing of the Good Friday Agreement. Given this context, it is unsurprising that Northern Ireland has high rates of conflict-related individual and intergenerational trauma. Many people self-medicate with substances to deal with conflict-related and other forms of trauma and mental health issues. This is a particularly problematic issue for people who use/d drugs in Northern Ireland given the absence of dual diagnosis services.

Pandemic restrictions, such as lockdowns, social distancing, remote schooling, working from home, reduced face-to-face services, have negatively impacted on emotional wellbeing, mental and physical health for many people who use/d drugs. It is likely that there will be increased levels of need among this population for several years given the ongoing impacts of the pandemic. At present, the voluntary and community sector is a crucial and primary source of support for many people who use/d drugs and experiencing mental health issues. Reliance on this sector is due to the absence of statutory dual diagnosis and constrained access to statutory mental health services. Rising levels of substance use, related harms and mental health issues necessitate accessible dual diagnosis services across sectors.

Substantial adverse impacts of the pandemic on family relationships for many clients were discerned. Increased drug use due to spending more time at home led to conflict and relationship breakdown. Subsequently, elevated numbers of family members engaged with NIADA services for help and support. Increased prevalence of hidden harm was also reported.

Impacts on the financial situation of people who use/d drugs varied dependent on employment status. However, the material and economic hardship of people dependent on drugs and/or those who inject drugs and/or those in the homeless community was severely exacerbated. The longer term impacts of the pandemic on employment and poverty combined with the current crisis in living costs will worsen economic hardship and may lead to increased acquisitive crime rates, involvement in drug markets and sex work which had already become more evident during fieldwork for this study.

Increased prevalence of domestic violence among people who use drugs was also identified during the pandemic. However, there are very limited domestic abuse services for people with complex needs who use drugs in Northern Ireland (Harris, 2018).

An important adverse outcome was increased rates of overdose and drug-related deaths following the first lockdown due to social isolation, long waiting times to access treatment services, using different substances, increased polydrug use, higher or inconsistent drug purity levels and public injecting in remote locations. During 2020, alcohol and drug-related deaths in Northern Ireland were at record levels (NISRA, 2022a,b). The continued high levels of alcohol and other drug-related deaths in Northern Ireland is extremely concerning.

7.1.1 Long-Term Recommendations

R1: *The DOH should develop and implement accessible dual diagnosis services for young people and adults throughout Northern Ireland and identify a timescale and budget. While these are being developed, voluntary, community and statutory substance use and mental health services need to work collectively to address clients' issues and avoid unnecessary and repeated referrals to services. Services must adapt to meet client needs, rather than expect clients' to fit services.*

R2: *Tackling alcohol and other drug-related deaths requires a long-term, strategic, coordinated, cross-departmental, cross-sectoral strategy. Clear objectives and strategies to reduce these unnecessary deaths need to be established. Evidence-based approaches, including the implementation of Overdose Prevention Sites, should be implemented.*

7.1.2 Short-Term Recommendations

R3: *The DOH should prioritise building a strong collaborative, cross-sectoral and cross-departmental approach to tackle the adverse health and social impacts of the pandemic on people who use/d drugs and their families. Ensuring accessible, inclusive and evidence-based treatment and support services for problematic substance use is pivotal. However, addressing the wider social determinants of their inequality, such as social and economic health inequalities, homelessness, criminalisation and trauma, is crucial to long-term change.*

R4: *Develop and expand accessible naloxone, managed alcohol programmes, overdose prevention educational materials and low threshold services to meet the needs of people who use alcohol and other drugs, including peer-led services, throughout Northern Ireland.*

R5: *There is clearly a need for more family support services in Northern Ireland, especially within rural areas, and this needs to be addressed in the short term. Providing additional one-to-one support for family members would ensure much needed support to deal with the harms of problematic substance use.*

R6: *Hidden harm protocols should be further embedded into services to make sure affected family members receive appropriate support including opportunities for family-based treatment opportunities.*

R7: *Stronger, fast-track referral pathways between substance use services to domestic abuse services are needed for people who use/d drugs. Specialist domestic abuse services, including refuge shelters, for people with complex needs who use drugs should be developed in Northern Ireland.*

R8: *Diversionary schemes away from the criminal justice system and into drug education, harm reduction or treatment should be implemented throughout Northern Ireland for low level, non-violent, drug-related offences. These schemes have the potential to reduce reoffending, costs of policing, improve the physical and mental health of people diverted, improve social and employment circumstances and reduce some drug use.*

7.2 Drug Markets, Use and Related Behaviours

Findings suggest that drug markets have remained relatively stable and resilient towards the impacts of the pandemic. Access to cocaine, online and street-sourced prescription drugs (particularly benzodiazepines) and synthetic cannabinoids appeared relatively unaffected. Heroin accessibility was constrained in some parts of Northern Ireland during the early stages of the pandemic. The cannabis resin market was affected and cost remains elevated. Importantly, when preferred drugs were not available or their purity decreased and/or cost increased, some people substituted or supplemented with other, sometimes more harmful, substances while others reduced or stopped their use.

A major drug market adaption during COVID-19 was increased use of online and surface web social media applications similar to other parts of the UK prior to the pandemic (Moyle et al., 2019). This study found that social messenger applications were more likely to be used by young people in comparison to more experienced people who use drugs with established contacts. Given uncertainty over the types, quality and purity of drugs purchased using this drug distribution method, there is increased potential for harm. Drug markets are strongly linked to patterns of drug use and related harms but very little academic research on drug distribution and associated harms has been conducted in Northern Ireland.

The findings show that for most people their current drug use patterns did not change significantly. However, where change did occur during the pandemic, it was mainly increased use attributed to a variety of reasons; including, boredom, feeling anxious or depressed, feelings of social isolation, limited contact with family and the availability and accessibility of drugs. These explanations point to the ongoing impacts of the pandemic on people who use/d drugs and emphasise the adverse impacts on mental health, the resilience of drug markets and continued accessibility of alcohol. Social distancing and infection control measures affected services, support networks and diversionary activities leading some people to relapse, increase or experience no change to their drug use.

People experiencing the most adverse health and social impacts of the pandemic were more likely to have maintained or increased drug use. They also tended to have weak social support networks, poor engagement with services, experienced heightened levels of social isolation and had difficulties engaging with services remotely either due to a preference for face-to-face services and/or technological barriers. Long waiting times and constrained access to statutory substance use and mental health services before and during the pandemic were also emphasised. The outlined issues particularly applied to older people living in remote rural locations in Northern Ireland and the homeless community.

Other qualitative data highlighted that some clients, especially young people, continued to meet with friends and peers despite pandemic restrictions. These social interactions provided the opportunity to source and use drugs. Substances were used to counteract boredom created by remote schooling, limited social support networks and diversionary activities due to infection control measures. Given this context, some young people have been very affected by the pandemic which increased susceptibility to drug use, mental health issues and risk-taking behaviours.

Data suggested that alcohol use had increased during the pandemic. Increased use was predominantly found among older, more socially isolated clients in rural areas who were typically furloughed or working from home or became unemployed during the pandemic. Elevated alcohol use among young people and other populations was also noted and attributed to the temporary inaccessibility of preferred drugs, boredom and other adverse health and social impacts. In addition, despite licensed venues reopening, some people were choosing to drink alcohol at home due to the reduced cost. However, home drinking could potentially increase harm due to the risk of consuming higher quantities.

It has been consistently reported that alcohol is the most harmful psychoactive substance (DOH, 2021a; WHO, 2014; Van Amsterdam et al., 2015; Nutt et al., 2010). The use of alcohol is very common in Northern Ireland and alcohol-related deaths are the highest on record (DOH, 2021a; NISRA, 2022a). Given increased use during the pandemic, rising levels of alcohol-related harms is concerning.

Recreational use of cocaine had become increasingly normalised for some groups of people prior to the pandemic in Northern Ireland. Infection control measures had impacted on settings where use occurred (e.g., closures of bars and nightclubs). Continued cocaine use became more visible in home settings prompting more people to seek help from services. More problematic use of injecting cocaine also became apparent among the homeless community predominantly in the BHSCT and SHECT which increased harm. Reasons for this trend included temporary inaccessibility, elevated cost and decrease purity of preferred drugs led some people to supplement or substitute with cocaine. The drug was widely available and cost appeared to decrease.

Cocaine-related deaths are also at elevated levels in Northern Ireland (NISRA, 2022b,c). The drug is currently the second most commonly reported drug by those presenting for help with problematic drug use (Foster et al., 2022). Therefore, elevated use of this drug during the pandemic and longer-term has the potential to increase cocaine-related harms.

Online and street-sourced prescription drug use also increased during the pandemic for similar reasons to increased cocaine use. It is important to note that prescribing rates for some of these drugs are much higher in Northern Ireland when compared to other parts of the UK in part due to the legacy of the political conflict (PAC, 2022). The use of diverted or illegally manufactured prescription drugs during the pandemic and uncertainty about the quality and potency of benzodiazepines and other illicitly manufactured prescription drugs increased harm. Data linked increased potency of these drugs to overdoses and drug-related deaths. The most recent official data on drug-related deaths in Northern Ireland reports that prescription drugs are involved in the majority of drug-related deaths and the number of people seeking treatment is substantial (NISRA, 2022b; PAC, 2022).

New and heightened drug use and risk behaviours became evident during the pandemic. Increased polydrug use and associated harms, including overdose, drug-related deaths and dependencies on multiple substances, was an important theme in this research. Reasons for elevated use included: increased access to counterfeit and prescribed benzodiazepines and other prescription drugs; substituting or supplementing preferred drugs due to temporary inaccessibility, decreased purity or elevated cost; and the increased transient nature of people using drugs within the homeless community. Given this context, polydrug use patterns and harms in BHSCT were replicated at a quicker rate in other HSCT areas. As a wide range of substances are being used, treatment and support is complex given the potential of multiple dependencies (EMCDDA, 2021b; NIAO, 2021b; DOH, 2021a; PAC, 2022). However, tacking polydrug use is crucial given that 66% of drug-related deaths in 2020 and 68% in 2021 involved two or more drugs (NISRA, 2022b,c).

Increased injecting-related harm during the pandemic was also evident. Although predominately confined to the BHSCT and SEHCT, the increase in HIV, HCV, groin injecting and injecting-related injuries is concerning. Reasons for elevated levels of harm included: more people in the homeless community injecting cocaine due to difficulties accessing preferred drugs; increased frequency of injecting cocaine and groin injecting; changing purity levels of preferred drugs; reduced cost and increased accessibility of cocaine. Constrained asses to NSES and statutory substance use services including OST also contributed. Similar to previous research (Rintoul and Campbell, 2021; Campbell et al., 2021; Higgins et al., 2020), a young more risk-adverse cohort in the homeless community were discerned. These people moved on to injecting cocaine and other drugs at a quicker rate with some transitioning straight to groin injecting. Their inexperience with injecting led to increased injecting-related injuries. Decreased motivations to implement harm reduction surrounding safer drug and injecting advice increased harm.

While the numbers engaging in high risk injecting practices were small, the harms are substantial. Increased rates of HIV and HCV are concerning. There is also the possibility of BBV transmission to other HSCTs and the general public given the transient nature of this client group combined with sexual relationships and transactional sex.

7.2.1 Long-Term Recommendations

R9: *Research on drug markets in Northern Ireland is needed to ensure drug trends and associated harms are monitored and emergent needs identified. Research into expanding cocaine, online and street-sourced prescription drugs, heroin, synthetic cannabinoids markets and use of online and surface web messenger applications is particularly required.*

R10: *Review, develop and expand accessible and inclusive substance use treatment and support provision across sectors. Developing highly accessible low threshold services and adapting existing statutory treatment services to fit clients' needs is particularly important for the homeless population. Expansion of services across sectors for people living in remote, rural locations of Northern Ireland is also required.*

7.2.2 Short-Term Recommendations

R11: *More harm reduction drug education and diversionary activities should be developed and implemented in schools and in the community for young people. These measures will help tackle boredom, prevent the escalation of substance use and/or polydrug use and related harm among young people. Expansion of these services is particularly needed in rural locations of Northern Ireland.*

R12: *To tackle alcohol-related harms, it is necessary to review, develop and implement strategies to restrict alcohol marketing ensuring children, young people and people recovering from alcohol dependence are protected. Reviewing the evidence-base for legislative change regarding the ability of alcohol minimum unit pricing to reduce harm is also important. Developing and implementing a public awareness campaign on the harms of problematic alcohol use will also help to mitigate potential harms.*

R13: *Review, develop and expand specific and accessible harm reduction advice, across sectors for alcohol use, recreational and more problematic forms of cocaine use, prescription drug use and polydrug use for young people and adults in consultation with peers. In particular, harm reduction interventions should prioritise the reduction of polydrug use given the connection with rising levels of drug-related deaths and other harms.*

R14: *To tackle the growth in injecting-related harms, including the spread of BBVs, it is critical to review, develop and expand harm reduction advice. Specific peer-led resources should be developed on safer injecting, promoting smoking heroin and snorting or swallowing cocaine, how to reduce injecting-related injuries and overdose. It is also important to develop and expand NSES within community pharmacies, outreach services, temporary accommodation settings and establish peer-led services to ensure adequate exchange services. Increasing BBV screening and testing while ensuring access to relevant treatment and support, including peer-led services, would also help mitigate harms.*

R15: *Given increased opioid-related overdoses, deaths, injecting-related harms and demand for the service, OST accessibility should be prioritised and provisions across the HSCTs reviewed in consultation with peers. A more flexible, accessible and accommodating approach towards OST should be adopted going forward*

7.3 Service Delivery

Findings have documented substantial changes to NIADA services due to social distancing and infection control measures. Increased demand for services and constrained access to statutory substance use and mental health services placed pressure and strain on services within the voluntary and community sector.

However, NIADA providers remained flexible, adaptive and responsive to changing patterns of drug use and related harms. New and innovative services were developed as patterns of drug use, related harms and needs were identified.

Despite the challenges of remote delivery and other adaptions to programmes, the majority of NIADA clients felt that changes had met their needs during the pandemic. Phone and online video-link services combined with the continuation and reinstatement of some face-to-face services were viewed as particularly beneficial.

Data has identified clear benefits and savings associated with phone and online video-link service delivery methods used by NIADA organisations. Better engagement in group and individual sessions, higher retention and completion rates were emphasised for some clients. Remote services also saved resources due to reduced travel time and lower DNA rates. There was agreement that a flexible, blended, hybrid model of face-to-face and remote services should be adopted going forward to ensure a person-centred, choice-based approach to service delivery.

However, it is important to be mindful of digital inequalities to avoid worsening existing health inequalities and social exclusion. Remote service delivery was particularly challenging for some people in the homeless community, those on probation orders, older people, those living in remote rural areas and with limited technological knowledge and/or resources. Concerns over confidentiality, assessing and managing clients' needs and risks, building trust and rapport with clients particularly in the early stages of engagement, staff training and resourcing must also be taken into consideration.

Increased financial support during the pandemic allowed NIADA services to adapt services to remote delivery and other formats, remain responsive to emerging drug use patterns and related harms through providing new services. However, continued financial investment is needed to combat the ongoing and longer term impacts of the pandemic on people who use/d drugs and their families and successfully implement the new drug strategy. Political, organisational and financial investment is also needed to ensure that services across sectors are evidence-based and sufficiently resourced to employ effective blended methods, resource and train staff and avoid long waiting times to access services.

Despite the essential services provided throughout the pandemic, voluntary and community sector services are vulnerable to having funding withdrawn when the government is under financial pressure which creates substantial uncertainty for organisations and the people who use their services (PAC, 2022).

Another essential important component of an effective, joined-up, collaborative approach to dealing with the adverse impacts of the pandemic on people who use/d drugs is the involvement of people who use/d drugs in the design and delivery of services. Research strongly supports positive outcomes of peer involvement in services including: reduced rates of drug-related harms; increased service access, acceptability and quality; changed risk behaviours and reduced stigma and discrimination (Chang et al., 2021; Marshall et al., 2015). While peer involvement within NIADA services was evident, there was a belief that more meaningful involvement of people who use/d services was needed in service design, delivery and policy to enhance services ability to target and reduce drug-related harms.

While referral routes between different services and tiers were present, a major issue identified was repeated and inconsistent referrals to statutory mental health and substance use services. This problem existed before the pandemic but it became more prominent especially for people in the homeless community who moved more frequently between HSCT. Using a more systematic and joined-up approach with a one point of referral would improve service accessibility, avoid unnecessary delays, reduce waiting times and avoid reassessment when clients move to a different HSCT.

A key area for improvement was the need to review and provide more in-patient residential detox and rehabilitation services for young people and adults due to increased demand for services during the pandemic. PAC (2022) and the NIAO (2020b) also recently highlighted that provision of these services was problematic as two HSCTs did not have formal access to detox beds resulting in some people with more complex needs being treated in the community when residential treatment would be more appropriate. According to PAC (2022), the DOH do not have a strategic regional plan for residential services and while promising a review of these services, this has not occurred. The current study also identified a review of these services was essential and more aftercare services to support clients' recovery should be developed and established.

As discussed, data suggested the most adversely affected clients' during the pandemic tended to be the most stigmatised and marginalised including people from the homeless community and/or injecting drug and/or were substance dependent. The internal and external stigma these people experience creates major barriers to uptake of services. Therefore, it is important to challenge stigma through targeted awareness, education and training.

Interconnected with reducing stigma and drug-related harms was the need to consider wider drug policy reform. Data suggested that growing levels of drug use and related harms combined with the normalisation of drugs, such as cannabis and cocaine, within Northern Ireland indicated that the current prohibitionist approach to dealing with drug use was not working. It was believed that adopting either a decriminalised or legalised approach would be cost-effective and help tackle the negative impacts of criminalisation, reduce drug-related harms, provide more resources for substance use treatment and support and disrupt organised crime groups.

This research is timely given the recent launch of the new substance use strategy in Northern Ireland (DOH, 2021). Findings contribute towards understanding the impact of the pandemic of people who use/d drugs and their families. The response of NIADA services, including strengths and challenges has been discussed and recommendations for going forward provided. This information will help inform the implementation of the new drug strategy in Northern Ireland. It is crucial that strategic actions and the operationalisation of the new drug policy is underpinned by quality research and evaluation to ensure effective, evidence-based services for people who use/d drugs and their families.

7.3.1 Long-Term Recommendations

R16: *An in-depth and more long-term evaluation is needed on remote delivery methods and adaptions to programmes due to social distancing and infection control measures to ensure implementation of the most effective, blended, hybrid methods to meet clients' immediate and continuing needs.*

R17: *There is a strong need for political, financial, cross-sectoral and cross-departmental investment and commitment to evaluate, monitor and develop substance use services in Northern Ireland. This investment is essential to the full implementation of the new drug strategy and to ensure that the unique adverse impacts of the pandemic on people who use/d drugs and their families are mitigated.*

R18: *Good practice of collaborative working during the pandemic should be continued and developed. Developing more collaboration and efficient interagency cooperation and coordination between the voluntary, community and statutory providers in the substance use and mental health sectors is needed to mitigate longer term adverse impacts of COVID-19 on people who use/d substances, their families and the strain this will place on services.*

R19: *Services provided in the voluntary and community sector are professional, cost-effective and use evidence-based methods. They should be considered as key long-term partners with statutory organisations when implementing the new substance use strategy while managing and responding to the ongoing impacts of COVID-19 on people who use/d drugs and their families.*

R20: *Investment must be made in ongoing research and evaluation during the course of the strategy as new challenges arise, knowledge evolves and evidence improves to ensure the needs of people who use/d drugs and their families are met.*

7.3.2 Short-Term Recommendations

R21: *Given the vital substance use and mental health services provided by the voluntary and community sector throughout the pandemic and the wide range of evidence-based services they provide, the DOH should provide more secure funding arrangements and contracts for these organisations.*

R22: *A single point of referral system for all clients throughout the HSCTs areas experiencing problematic substance use and those with dual diagnosis should be established.*

R23: *There is an urgent need to review accessibility and provision of residential detox and rehabilitation treatment given unequal access and increased demands for these services.*

R24: *Develop and implement more evidence-based aftercare services and support for young people and adults to meet the needs of people recovering from problematic substance use.*

R25: *It is vitally important to establish meaningful co-production, co-design and co-delivery of substance use treatment and support services with people who have use/d drugs.*

R26: *To challenge the stigma surrounding people who use/d drugs, public awareness and information campaigns informed by service providers and people who use/d drugs should be further developed and implemented. All health and social care professionals providing substance use and mental health services should have ongoing training on drug use. The benefits of adopting a person-centred, trauma-informed, strengths-based approach to tackle substance dependency should be emphasised.*

References

References

ASCERT (2020)

ASCERT Service User Survey on Impact of Coronavirus Pandemic: First Report. ASCERT.

Ballantine, J.A. Rouse, M. and Gray, AM. (2021)

Gender Budgeting: What does the literature tell us? Lessons from Northern Ireland. ARK Working Papers.

https://www.ark.ac.uk/ARK/sites/default/files/2021-02/Gender_Budgeting-1.pdf

Bauermeister, J.A. Zimmerman, M.A. Johns, M.M. Glowacki, P. Stoddard, S. and Volz, E. (2012)

Innovative recruitment using online networks: lessons learned from an online study of alcohol and other drug use utilizing a web-based, respondent-driven sampling (webRDS) strategy. *Journal of Studies on Alcohol and Drugs.* Vol. 73(5), pp. 834–8.

Bennett, A.S. Townsend, T. and Elliott L. (2021)

The COVID-19 pandemic and the health of people who use illicit opioids in New York City, the first 12 months. *International Journal of Drug Policy.* Vol. 101.

Braun, V. and Clarke, V. (2021)

Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytical approaches. *Counselling and Psychotherapy Research.* Vol. 21(1), pp. 37-47.

British Academy (2021)

The COVID Decade: Understanding the long-term societal impacts of COVID-19. The British Academy. https://www.thebritishacademy.ac.uk/publications/covid-decade-understanding-the-long-term-societal-impacts-of-covid-19/

British Society of Criminology (2015)

Statement of Ethics.

https://www.britsoccrim.org/documents/BSCEthics2015.pdf

Bruton, L. Featherstone, T. and Gibney, S. (2021)

Impact of COVID-19 on Drug and Alcohol Services and People who use Drugs in Ireland: A report of survey findings. R & D and Health Analytics Division Department of Health.

https://igees.gov.ie/wp-content/uploads/2021/01/Covid-Rapid-Impact-Assessment.pdf

Campbell, A. Faulkner, K. Rintoul, C. and Cameron, I. (2021)

Drug use and street homelessness during a pandemic: synergetic working with a vulnerable population. In Beresford, P. Farr, M. Hickey, G. Kaur, M. Ocloo, J. Tembo, D. and Williams, O. (eds) *COVID-19 and Co-production in Health and Social Care Research, Policy and Practice. Bristol University Press, Policy Press.*

https://www.jstor.org/stable/j.ctv1p6hqjs.18#metadata_info_tab_contents

Carter, N. Bryant-Lukosius, D. DiCenso, A. Blythe, J. and Neville, A.J. (2014)

The Use of Triangulation in Qualitative Research. *Oncology Nursing Forum.* Vol. 41(5), pp. *545-547.*

Chang, J. Shelly, S. Busz, M. Stoicescu, C. Iryawan, A.R. Madybaeva, D. de Boer, Y. and Guise, A. (2021)

Peer driven or driven peers? A rapid review of peer involvement of people who use drugs in HIV and harm reduction services in low- and middle-income countries. *Harm Reduction Journal.* Vol. 18 (15).

Creswell, J.W. and Plano, C.V.L. (2018)

Designing and Conducting Mixed Methods Research. Third Edition. Thousand Oaks: SAGE.

Croxford, S. Emanuel, E. Ibitoye, A. Njoroge, J. Edmundson, M. Bardsley, M. and Phipps, E. (2021)

Preliminary indications of the burden of COVID-19 among people who inject drugs in England and Northern Ireland and the impact on access to health and harm reduction services. *Public Health.* Vol. 1992, p.p. 8-11.

Department of Health (2020)

Guidance for Alcohol and Drug services in Northern Ireland to best deliver treatment and care during the COVID-19 pandemic. DOH.

https://www.health-ni.gov.uk/sites/default/files/publications/health/guidance-for-alcohol-drug-services-during-the-covid-19-pandemic-sept-2020.pdf

Department of Health (2021b)

Mental Health Strategy: 2021-2031.

https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mhs-strategy-2021-2031.pdf

Department of Health (2021a)

Preventing Harm, Empowering Recovery - Substance Use Strategy: A Strategic Framework to Tackle the Harm from Substance Use (2021-31). DOH.

https://www.health-ni.gov.uk/publications/substance-use-strategy-2021-3

Denzin, N.K. (1989)

The research act: A theoretical introduction to sociological methods. Third Edition. New York: McGraw-Hill.

Etheridge, B. and Spantig, L. (2022)

The gender gap in mental wellbeing at the outset of the COVID-19 pandemic: Evidence from the UK. *European Economic Review.* Vol. 145.

Ethical Research Involving Children (2021)

Ethical Guidance.

https://childethics.com/ethical-guidance/

EMCDDA (2022)

European Drug Report: Trends and Developments. EMCDDA.

https://www.emcdda.europa.eu/system/files/publications/14644/EDR_2022_18-ONLINE.pdf

EMCDDA (2021a)

Impact of COVID-19 on drug markets, use, harms and drug services in the community and prisons. EMCDDA.

https://www.emcdda.europa.eu/publications/ad-hoc-publication/impact-covid-19-drug-markets-use-harms-and-drug-services-community-and-prisons_en

EMCDDA (2021b)

Polydrug Use: Health and Social Responses. EMCDDA.

https://www.emcdda.europa.eu/publications/mini-guides/polydrug-use-health-and-social-responses_en#section2

Fielding, N.G. Lee, R.M. and Blank, G. (2017)

The Sage Handbook of Online Research Methods. London: Sage.

Foster, J.H. Martin, C. and Davis, J.P. (2021)

Alcohol consumption during the COVID-19 lockdown period: predictors of at-risk drinking at different AUDIT-C cut-off thresholds. *International Journal of Environmental Research and Public Health.* Vol. 18(24).

Foster, C. Scarlett, M. and Stewart, B. (2022)

Statistics from the Northern Ireland Substance Misuse Database: 1 April 2020 – 31 March 2021. Information Analysis Directorate, DOH.

https://www.health-ni.gov.uk/sites/default/files/publications/health/smd-20-21.pdf

Harris, J. (2018)

Initiations and Transitions to and from Injecting Drug Use and Heroin Use. Belfast: Unpublished Doctoral Thesis, QUB.

Health Research Authority (2021)

UK Policy Framework for Health and Social Care Research.

https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/uk-policy-framework-health-and-social-care-research/

HSC (2020)

The Mental Health Impact of the COVID-19 Pandemic in Northern Ireland: A Rapid Review.

https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-impact-covid-pandemic.pdf

Higgins, K. Kelly, G. and Campbell, A. (2020)

Northern Ireland Alcohol and Drugs Alliance: Service users experiences during lockdown. NIADA.

https://www.qub.ac.uk/research-centres/cesi/Filestore/Filetoupload,1004567,en.pdf

Housing Executive (2020)

The Way Home: Homelessness Response to COVID-19. HE.

https://www.nihe.gov.uk/Documents/Homelessness/homelessness-reset-plan-the-way-home

Hughes, J. IJpelaar, J. McAuley, R. and Lyness, D. (2021)

Alcohol-specific Deaths in Northern Ireland: Socio-Demographic Analyses. NISRA.

https://www.nisra.gov.uk/system/files/statistics/Socio-economic%20Associations%20of%20Alcohol-specific%20Mortality%20-%20Research%20Report.pdf

Hughes, J. IJpelaar, J. and Lyness, D. (2020)

Drug-related Deaths in Northern Ireland: Socio-Demographic Analyses. NISRA.

https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Drug-related%20Deaths%20in%20Northern%20Ireland%20-%20Findings.pdf

Information Analysis Directorate (2019)

Census of Drug and Alcohol Treatment Services in Northern Ireland: 30th April 2019. DOH.

https://www.health-ni.gov.uk/sites/default/files/publications/health/drug-alcohol-census-2019.html

Kesten, J.M. Holland, A. Linton, M.K. Family, H. Scott, J. Horwood, J. and Hines, L.A. (2021).

Living under coronavirus and injecting drugs in Bristol (LUCID-B): A qualitative study of experiences of COVID-19 among people who inject drugs. *International Journal of Drug Policy.* Vol. 98.

Marshall, Z. Dechman, M. Micichiello, A. Alcock, A. and Harris, G. (2015)

Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives. *Drug and Alcohol Dependence.* Vol. 151, pp. 1-14.

May, T. Dawes, J, Fancourt, D. and Burton, A. (2022)

A qualitative study exploring the impact of the COVID-19 pandemic on People Who Inject Drugs (PWID) and drug service provision in the UK: PWID and service provider perspectives. *International Journal of Drug Policy.* Vol. 106.

McCracken, N. (2020)

Northern Ireland drug gangs 'turn to dark web and social media'. *BBC News.*

https://www.bbc.co.uk/news/uk-northern-ireland-53185958

Moyle, L. Childs, A. Coomber, R. and Barratt, M.J. (2019)

#Drugsforsale: An exploration of the use of social media and encrypted messaging apps to supply and access drugs. *International Journal of Drug Policy.* Vol. 63, pp. 101-110.

Northern Ireland Audit Office (2021)

Second Report – Overview of the Northern Ireland Executive's Response to the COVID-19 Pandemic. NIAO.

https://www.niauditoffice.gov.uk/files/niauditoffice/media-files/Overview%20of%20the%20Northern%20Ireland%20Executive%27s%20Response%20to%20the%20COVID-10%20Pa.._.pdf

Northern Ireland Audit Office (2020b)

Addiction Services in Northern Ireland. NIAO

https://www.niauditoffice.gov.uk/files/niauditoffice/media-files/235243%20NIAO%20Addictions%20Services%20Report__NEW%204.pdf

Northern Ireland Audit Office (2020a)

Overview of the Northern Ireland Executive's Response to the COVID-19 Pandemic. NIAO.

https://www.niauditoffice.gov.uk/files/niauditoffice/media-files/NIAO%20Report%20-%20Overview%20of%20the%20Northern%20Ireland%20Executive%E2%80%99s%20response%20to%20the%20COVID-19%20pandemic.pdf

Northern Ireland Drug and Alcohol Alliance (2022)

About NIADA. NIADA.

https://www.niada.net/about-us/

Northern Ireland Statistics and Research Agency (2022a)

Alcohol Specific Deaths in Northern Ireland, 2020. NISRA.

https://www.nisra.gov.uk/system/files/statistics/Alcohol-Specific%20Deaths%20in%20NI%202020.pdf

Northern Ireland Statistics and Research Agency (2022b)

Drug-related and drug-misuse deaths in Northern Ireland, 2020. NISRA.

https://www.nisra.gov.uk/system/files/statistics/FI1%2022%20730060%20%20Drug%20Deaths%20in%20NI%202020%20-%20revised%20June%202022.pdf

Northern Ireland Statistics and Research Agency (2022c)

Drug-related and drug-misuse deaths in Northern Ireland, 2021. NISRA.

https://www.nisra.gov.uk/system/files/statistics/Drug%20Deaths%20in%20NI%202021.pdf

Northern Ireland Statistics and Research Agency (2019)

Economic Inactivity in Northern Ireland.

https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Economic%20Inactivity%20in%20Northern%20Ireland.pdf

Nutt, D.J. King, L.A. and Phillips, L.D. (2010)

Drug Harms in the UK: A Multicriteria Decision Analysis. *Lancet*. Vol. 376, pp. 1558-1565.

Public Accounts Committee (2022)

Addiction Services in Northern Ireland.
Northern Ireland Assembly.

http://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/pac/reports/addiction-services-ni/report-on-addiction-services-in-northern-ireland.pdf

Public Health England (2021)

Unlinked Anonymous Monitoring (UAM) Survey of HIV and viral hepatitis among PWID: 2021 report. Health Protection Report. Vol. 15 (3)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1006242/hpr1321_uam-pwid.pdf

Rintoul, C. and Campbell, A. (2021)

Groin Injecting in Northern Ireland: Views of the Experts by Experience. Extern.

https://www.extern.org/groin-injecting-in-northern-ireland-views-of-the-experts-by-experience

Seale, C. (2017)

Researching Society and Culture. Fourth Edition.
London: SAGE.

Seddon, J. Trevena, P. Wadd, S. Elliott, L. Dutton, M. McCann, M and Willmott, S. (2022)

Addressing the needs of older adults receiving alcohol treatment during the COVID-19 pandemic: a qualitative study. *Aging and Mental Health*. Vol. 26(5), pp. 919-924.

Van Amsterdam, J. Nutt, D.J. and Phillips, L. (2015)

European Rating of Drug Harms. *Journal of Psychopharmacology*. Vol. 29, pp. 655-660.

Vasylyeva, T.I. Smyrnov, P. Strathdee, S. and Friedman, S.R. (2020)

Challenges posed by COVID-19 to people who inject drugs and lessons from other outbreaks. *Journal of the International AIDS Society*. Vol. 23 (7).

World Health Organisation (2022)

COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide. WHO.

https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

World Health Organisation (2015)

Global Status Report on Alcohol and Health 2014.
Geneva: WHO.