ASCERT response to the draft Making Life Better – Preventing Harm & Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use

Introduction

ASCERT is supporting of the strategy overall and believes that ambitions within it represent an opportunity to address alcohol and substance use and other related issues hrough a more integrated and complete approach. We particularly welcome the recognition of the connectivity of substance use with other issues such as mental health, suicide and homelessness and the need to address these issues together. We also welcome greater focus on prevention and recovery. Many of the actions are substantial and require significant change in how things currently work, which will be very challenging. It is therefore essential that there are robust governance and accountability processes and effective implementation structures to support the successful delivery of that change and achievement of the strategies outcomes for the benefit of service users. We would be concerned that the ambitions of the strategy will require significant additional investment and that there therefore needs to be a firm commitment that sufficient resources will be available.

Vision

We agree with the proposed vision of the strategy

Outcomes

We agree with the outcomes proposed. However, we believe that given the acknowledged importance of the linkage to mental health, the need to align the strategy to the mental health strategy and the number of actions that relate to co-existing mental health issues and suicide prevention, there should be an additional outcome specifically about reducing harm by addressing co-existing issues, and associated actions to deliver this.

Workforce development has been identified as a priority but it is our opinion that as a cross cutting issue that is a critical to the delivery of the strategy it should be a specific outcome, that the workforce across the statutory, voluntary and community sectors has the capacity and skills to deliver on the strategy and respond to need. This should be supported with a workforce development strategy and associated actions.

Outcomes and priorities should have identified indicators that can demonstrate that the strategies success in addressing these.

Values

We agree in general with the values in the strategy. In our opinion the success of the strategy depends on the evidence of these values in its delivery and recommend that the evaluation and monitoring of the strategy should include methods to assess that the values are being demonstrated in its implementation.

The value *Shared Responsibility, Co-Production and Collaboration – Health-led* should be reflected in the implementation of the strategy and accountability

processes to ensure that this value is being evidenced at all levels. Co-production and collaboration can sometimes be superficial and focussed on consultation and development, and not as well reflected in monitoring and quality assurance of processes and services, incorporating meaningful ongoing engagement with service users.

It is also important that this value is also evidenced between planners and commissioners. There has long been an argument for joint planning and commissioning of services, pooling resources and working together to unlock barriers and problems across systems and areas of responsibility. So much of the strategy requires different ways of doing things and connection between systems and services, yet the most common objections from service users relate to the barriers they face because the lack of integration and communication across systems and services.

We suggest that the *Universal, but with an increased focus on those most at risk* value should include reference to children living with hidden harm and people with co-existing drug and alcohol and mental health issues.

There is a value of having a *long-term focus,* but there are no timeframes in the strategy. It would be important that there are timeframes against the actions in order to understand which are of short, medium and long term focus. We welcome reference to focusing as much on prevention and early intervention and think that this should be reflected in the actions and resources allocated.

OUTCOME A – FEWER PEOPLE ARE AT RISK OF HARM FROM THE USE OF ALCOHOL AND OTHER DRUGS

A2. A Northern Ireland Prevention Approach, based on up-to-date evidence and an analysis of the risk and protective factors impacting our young people, will be developed by the PHA and delivered in Northern Ireland and reviewed after 5 years – while this will be a universal programme, it should also be targeted at those at most risk and those in disadvantaged communities.

Response: We welcome recognition of the need for a strategic approach to prevention. We think the overall prevention strategy should be over the life-course. This should be a cross departmental approach and include research to monitor impact. There needs to be much better engagement between EA statutory youth services and DACTs and with voluntary and community sector providers as approaches in schools and statutory youth services are disjointed.

ASCERT supports an approach such as the ‘Planet Youth’ model as an evidence based whole system model for prevention in order to increase protective factors in their environment and reduce risk factors. The success of this model has been as a result of core approaches that included developing a long term, community focussed approach based on live research with young people of the risk factors present for them. A co-ordinated collaborative approach employing strategies to build key protective factors, and supported by ongoing research resulted in changes that

better protected young people and in changed behaviour of young people, families and communities. It is essential that we employ a NI wide approach incorporating the learning from this model and commit to it over the long term for best effect.

A3. The PHA will update the drugandalcoholni.info website with up-to-date information in terms of substance use and the services available in Northern Ireland.

Response: What would be useful is for digital tools for self-help and recovery to be developed and be promoted to services to incorporate into their delivery models and supports for their service users.

A4. The current community support mechanisms will be reviewed by the PHA to ensure they can support the local implementation of this Strategy in the community, promote prevention, collaboration and access to services.

Response: This appears to refer to the DACT connections service. If this is the case, then it would be helpful to specify if this is the case and whether the review also involves any other community support mechanisms or services. If this is a review of the DACT connection service then it should be undertaken as part of the review of DACTs in section 12.7 of the strategy.

A6. The Making Every Contact Count programme in primary care will include brief interventions and advice in respect of alcohol and drug use.

Response: This action should be widened beyond the programme in primary care to include the use of brief interventions in other settings including the community. Local evidence of use of self-help materials and brief interventions in other settings is encouraging, for example the Alcohol and You service in SEHSCT, and PHA funded Step 2 Services are examples of community based services that demonstrate good outcomes from self-help materials, brief advice and brief treatment, particularly where people are drinking or using substances hazardously. The drugandalcoholni.info website has brief advice tools for setting specific populations including Family and Childcare, Hospital, Mental Health, Maternity, and the Community. In an environment where there is evidence of increased hazardous and harmful drinking and drug use in the population in coping with the COVID-19 pandemic, the strategy should be promoting the embedding brief intervention approaches at Tiers 1 and 2 in order to provide early intervention to more people in the community and supporting this through training and research.

A8. The Hidden Harm Action Plan will be updated by the PHA and the HSCB to ensure that supports are in place, in a stepped care approach, to mitigate the risk for those children and young people who live with substance misusing parents or carers, in particular the Joint Working Protocol on Hidden Harm will be promoted and used across all services.

Response: There should be a clear model of support and pathways across all tiers to respond to hidden harm. Training should be made available to the workforce across sectors and tiers to make them more aware of hidden harm and in evidence based interventions to support young people and families affected by hidden harm, for example the Steps to Cope intervention for young people. The PHA should

continue to commission specialist hidden harm services and extend the remit of the youth treatment service to include supporting children experiencing hidden harm.

A9. The PHA will promote and raise awareness of the UK Chief Medical Officer low-risk drinking guidelines and understanding of alcohol units across the region.

Response: We agree with this action, however it should go further. Awareness of the guidelines and units on its own does not sufficiently influence behaviour. There should be a consideration for further actions to improve health literacy, in other words the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions. This should also be supported by increasing the availability of early and brief interventions that aim to reduce hazardous and harmful levels of alcohol use. As we have already indicated in our response to A6, there should be a concerted effort to empower the workforce across at tier 1 and 2 settings to engage people with brief advice and brief intervention models.

A10. The Department for Infrastructure will seek to improve access to its Course for Drink Drive Offenders scheme – a rehabilitation scheme that aims, through education, to make drink drive offenders take more responsibility for their actions and reduce the risk of re-offending.

Response: There should be a similar intervention for driving under the influence of drugs.

OUTCOME B - LEGISLATION AND THE JUSTICE SYSTEM SUPPORT PREVENTING AND REDUCING THE HARM RELATED TO SUBSTANCE USE.

Indicators: An indicator of how many people in the justice system accessing treatment for their drug or alcohol use should be considered as this can be a more useful and positive indicator than solely measuring the number of people with drug or alcohol problems.

B2. Appropriate services, and treatment where applicable, should be provided to those who come into contact with the justice system. As part of this, a new transition service will be developed and tested by the SEHSCT Prisons Healthcare team. This will aim to better coordinate the continuity of care for those being released from prison into the community, including connections towards ongoing appointments and treatments. Service users will be navigated towards the community/voluntary sector and peer support as an integral part of these arrangements.

Response: Prison policies of zero tolerance approaches in custodial settings do not work and can be a barrier to seeking help. Responses to substance use should be focused on encouraging engagement in treatment and support. Better services are needed for both sentenced and remanded prisoners and to prepare them for release and support their integration in the community. The action should include introducing arrangements that fast-track access to addiction related services, housing, mental health and other supports.

B3. Work on a new Liquor Licensing Bill being taken forward by the Department for Communities provides an opportunity to strengthen alcohol licensing laws in Northern Ireland and ensure it takes account of public health issues.

Response: This should take account of evidence of increased alcohol related harm in areas of high density of alcohol outlets and areas of deprivation.

B5. The Department of Health will work with the UK Government to tighten restrictions on the advertising of alcohol, including given consideration to the introduction of a 9pm "watershed".

Response: Restrictions on the marketing of alcohol can be a useful tool but we recommend that the objective of this action should be to make restrictions up to a total ban on alcohol advertising.

OUTCOME C – REDUCTION IN THE HARM CAUSED BY SUBSTANCE USE

The indicators do not reflect the harm from complexity such as co-existing mental health issues. As this is a priority issue in the strategy, in addition to the rate of alcohol/drug related hospital admissions, it should also include indicators for numbers of presentations and admissions where there are both alcohol or drug and mental health issues.

In order to be more effective in reducing harm, particularly with vulnerable and more hard to reach groups, a greater emphasis on outreach and collaboration services, home detox, community based services, shared care arrangements.

C4. Suicide prevention training will be provided to all staff working in substance use related services.

Response: We agree that suicide prevention training should be provided to substance use related services, but given the strategy has supporting people with co-occurring mental health and substance use as a priority this action should be to build the capacity of services across both mental health and substance use to prevent suicide.

Furthermore, risk of suicide will be reduced by making improvements to the quality of supports people get when they need it. As we have already said earlier in this response, given the close relationship between drug and alcohol issues and mental health it is a critical that we reduce the obstacles and stresses that people face when getting support for these issues by ensuring that services can respond to both drug and alcohol, and metal health needs. More training is needed across both service areas and at all tiers. Substance use related services should have access to mental health and suicide prevention training and mental health services will have access to drug and alcohol training including delivering brief interventions.

OUTCOME D – PEOPLE ACCESS HIGH QUALITY TREATMENT AND SUPPORT SERVICES TO REDUCE HARM AND EMPOWER RECOVERY

Indicators

It is essential that services are configured to ensure people get the right support at the right time, and reducing waiting times is important, but it is also essential that we increase the engagement rate. It is our understanding that it is common that more than half of those referred to Community Addiction Teams disengage before they can receive support. This may be for reasons including the time elapsed since referral or not being motivated to engage. Therefore the gap between referrals and engagement in treatment should be a key inequality that we should be trying to close. In addition to waiting times and numbers waiting for treatment a suitable indicator would be numbers referred to treatment services that do not engage.

D2. The PHA and the HSCB will ensure that self-care advice and support is available through a range of sources, including online, via apps, etc.

Response: Take up of self help should be included in research and monitoring.

D3. The PHA will continue to deliver a programme of workforce development in relation to substance use, in line with national standards such as DANOS etc. This would include the need for a trauma-informed approach and appropriate training on stigma associated with substance use.

Response: This programme should be guided by a regional workforce development strategy. This should define the standards required for drug and alcohol roles across the workforce and include a clear plan for developing the workforce based on what is needed for each sector across the tiers and in support of the substance use strategy and to meet service needs. We agree that training should support a traumas informed approach and address stigma, and suggest that this action should include that training would also support self-care for staff.

D4. The PHA and the HSCB will revise the Alcohol and Drug Commissioning Framework for Northern Ireland to produce a new strategic plan that is outcomes focused and in line with the strategy, evidence and best practice guidelines. This new plan should:

- ensure that the population of NI have access to a continuum of service with clear pathways and step up/step down provision;
- ensure that all services are delivered in line with the UK-wide “Drug Misuse and Dependence: Guidelines on Clinical Management”;
- provide support to address the wider physical, mental health, and wellbeing needs of those in treatment, including housing, education, employment, personal finance, healthcare e.g. they should be supported to stop smoking and address other physical health conditions;
- recognise the importance of co-production and strengthen joint working between the community and voluntary sector, service users and peers, and the Health and Social Care Sector; and

- develop a clear governance structure to provide oversight and support consistent implementation of the priorities identified within the strategy across the region.

Response: We strongly agree that there must be a strategic commissioning plan for Northern Ireland. It is vital that the Alcohol and Drug Commissioning Framework should be widened beyond the PHA and HSCB to include the commissioning of all drug and alcohol services. The purpose of the framework should be to describe the service models that should be in place to deliver the strategy across the entire commissioning environment.

The Northern Ireland Alcohol and Drug Alliance, which includes ASCERT has already raised concerns that the PHA are planning to undertake a procurement of its drug and alcohol services in 2021, ahead of the revision of the commissioning framework. The commissioning framework should determine the services needed to deliver the strategy and so the procurement of PHA services now, which represent the bulk of the services proposed in this strategy, simply puts the cart before the horse and other approaches should be considered in order to ensure a continuity of service until a strategic commissioning framework is produced.

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

This pressure becomes of even less value if the PHA proceeds with full procurement but reduces the proposed contract term to align with the substance use strategy. We would strongly urge that the procurement of services is delayed until a comprehensive commissioning framework has been designed that defines the service models needed across the commissioning bodies to implement the regional strategy and meet service user needs.

D5. A review of Tier 3 services (to include pathways and linkages to Tier 2 services) will be completed, with the development of an implementation plan to increase access to services to those most at risk and to reduce waiting times.

Response: The majority of people with drug and alcohol problems can be best supported by Services provided at tiers 2 and 3. There is a need for an integrated model of care across all tiers, but particularly in tiers 2 and 3. An effective model across tiers 2 and 3 would be a key strategy to relieving pressure on statutory addiction services, by engaging more people at tier 2 before they require more intensive tier 3 support.

This action should be revised to be a review of Tier 2 and 3 services and also the linkages with mental health services. This would inform the service configurations needed across the tiers and in each sector within a context of a continuum of services and more effectively address issues such as access, step up and down and shared care.

The review should consider other earlier intervention models that can support tier 2 services such as MI brief treatment as suggested by the QUB school of public health evaluation of the Alcohol and You service as an effective engagement model at tier 2 that can deliver as effective outcomes as more intensive interventions.

D6. The PHA and the HSCB will review services available for children and young people, particularly looking at the transition of young people from children to adult services. This will include standalone services commissioned by the PHA, and the expansion of the DAMHS service
within CAMHS.

Response: We welcome this action and the acknowledgement of the need to include the transition of young people from children to adult services. A review of services should include ensuring there is a suitable stepped care model for young people affected by substance use, including hidden harm. We support the expansion of the DAMHS service but given the high numbers of young people presenting to youth drug and alcohol services with undiagnosed mental health issues, it should also focus on improving the relationship and pathways between supports for drug and alcohol use and mental health services. It is also important that this review considers evidenced family supports that should be included in service models that can build family skills and resilience as supports for young people.

D7 The HSCB will review the support provided for those with co-occurring mental health and substance use issues urgently, to ensure that services are delivered in line with the relevant guidelines and ensure collaboration across all key services.

Response: It is important that this action look sat this issue across tiers, and adult and young people's services. The action should include development of integrated model of care and pathways across drug and alcohol and mental health services.

OUTCOME E – PEOPLE ARE EMPOWERED AND SUPPORTED ON THEIR RECOVERY JOURNEY

E1: The Department of Health, the PHA and the HSCB will work with experts and key stakeholders, including those with lived experience, to address stigma as a way of reducing barriers to seeking treatment, to improve prevention and to reduce harm.

Response: It would be helpful if there was definition of some actions that will be taken to address stigma. It is important that work is done that helps normalises accessing treatment and support for drug and alcohol problems, encouraging engagement and reducing stigma for service users and for families of service users in the community.

E2: We will build on the regional structure in place to support the involvement of experts by experience, service users and their families at all implementation levels of this strategy, from policy development to local service design and delivery.

Response: We support this action and recommend that it specifies that this includes young people, as currently most service user involvement processes primarily involve adults.

There should be an additional action to support the development of service user involvement in services. Our ambition should be improve the quality of involvement of service users in services as this will in turn improve the quality of services, however resources, time and access to evidence based advice and support are obstacles for many organisations. There should be an initiative to provide practical support to organisations to help them develop their engagement and involvement processes.

E3: The PHA, the HSCB and Health & Social Care Trusts will work with service users and their families to support the development of recovery communities, mutual aid and peer-led support including research throughout Northern Ireland.

Response: We welcome this action. It is important that the transition from intervention to recovery supports is improved and embedded in service models. The action should include that drug and alcohol service commissioned would include recovery models and pathways to further supports to aid recovery. We support all recovery support but not all recovery models work for each person. It is important that there are a menu of options available in addition to traditional mutual aid groups such as AA and NA and that can be promoted as supports earlier in the recovery journey.

OUTCOME F – INFORMATION, EVALUATION AND RESEARCH BETTER SUPPORTS STRATEGY DEVELOPMENT, IMPLEMENTATION AND QUALITY IMPROVEMENT

We welcome a commitment that services should be monitored on the outcomes they deliver. It is also important that work is done to develop better sources of data and indicators that define need and can monitor high level outcomes as well as service level outcomes and that this informs actions and services.

F3: The HSCB will develop an outcomes framework for all Tier 3 and Tier 4 services to monitor the impact and effectiveness of these services. Tier 1 and 2 services commissioned by the PHA will continue to be required to complete the Impact Measurement Tool.

Response: We welcome the development of an outcomes framework for tier 3 and 4 but argue that this should not stand alone. All services should have clear outcomes but this should be within an integrated outcomes framework across tiers 1 to 4. This action is a missed opportunity to support a more integrated model of care in a stepped care approach and fails to recognise the fact that many people move between tiers of support particularly between tiers 2 and 3, and in some services they are providing both tier 2 and 3 work. It does not make sense to have separate outcomes frameworks. It also could be interpreted that this action intends that there should be a different approach to outcomes monitoring in the statutory

sector and voluntary sector as the IMT is only used by the PHA commissioned services.

An outcomes framework should also include defined outcomes for young people, adults, family members and families, as supports are provided for individuals with alcohol and substance use problems, family members affected by another persons use and family units.

MAKING IT HAPPEN – GOVERNANCE and STRUCTURES

12.4 The Public Health Agency and the Health & Social Care Board will establish a new Regional Implementation Board to oversee the delivery of the strategy within the Health & Social Care Sector, and to align with key partners in other sectors. To avoid duplication and to ensure alignment of the strategic direction across both this strategy and the forthcoming Mental Health Strategy, this implementation board will also serve as part of the governance and delivery structures for the Mental Health Strategy

12.6 Preventing Harm, Empowering Recovery clearly recognises that local assessment of need, and the development and delivery of services, programmes and initiatives to meet these needs, is paramount to address these issues effectively. It is therefore vital that local structures are in place that support these functions. Previously these had been delivered through the local Drug and Alcohol Co-ordination teams (DACTs), supported by the PHA and the DACTs Connections Service.

12.7 However, the local delivery landscape has changed dramatically in recent years. Policing and Community Safety Partnerships (PCSPs) are now well established and Community Planning structures at local government level also now exist. We believe there is still a need for local partnerships focused specifically on the harm related to the use of alcohol and other drugs, however, it would now be appropriate for the PHA to review the role, function and membership of Drug & Alcohol Co-ordination Teams, supported by DoH and other partners, to ensure they are effective and strategically placed to inform, support and monitor the delivery of Preventing Harm, Empowering Recovery.

This review should include an assessment of the linkages and overlaps with other local delivery structures. DACTs will remain in place until this review is completed.

Response:

A weakness of the NSDAD arrangements was a disconnect between strategy and implementation structures and bodies.

There should be governance and accountability arrangements with clear lines of reporting to ensure that the strategy is being delivered across partners and through its structures.

We support the intention for alignment between the substance use mental health strategies through a shared regional implementation board. We believe this needs to be reflected throughout the implementation structures regionally and at local levels

with greater alignment between DACTs, Community Planning, Mental health communities of interest, Protect Life Implementation Groups and other relevant groups.

The strategy needs to be flexible and local mechanisms such as the DACTs should have a role in engaging and supporting the community and influencing resources to respond to changing needs.

Commissioning processes should also be flexible to be able to respond to changing needs over the lifetime of the strategy.

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