Alcohol and Drug Commissioning Framework for Northern Ireland 2013-16

Partnership Consultation Response

By DAISY East and West and Targeted Education Services

April 2013

Introduction

Opportunity Youth and ASCERT have considered the Commissioning Framework document recently produced by the Public Health Agency and Health and Social Care Board of Northern Ireland. As a Partnership responsible for the DAISY East and West Youth Treatment Services and the Targeted Education Service, we are responding primarily to the Children and Young People Section of the framework. Opportunity Youth and ASCERT have also responded separately on the areas of Community Support and Adults and the General Public. We would request that the PHA also take note of the paper that we sent in December 2012, in which several points are made which remain relevant. We attach this for additional information.

Opportunity Youth and ASCERT have been working in partnership for the last four years, delivering the DAISY and Targeted Education Services. We have had a strong contractual relationship with the Public Health Agency throughout this time. The partnership has also built up strong networks across the Health and Social Care Trusts within which our services are delivered. We have well established networks across all sectors and work in collaboration with a wide range of agencies to deliver highly effective and quality education and support services to young people.

Opportunity Youth and ASCERT are interested in all tiers of the NSD, including workforce development, prevention and early intervention and 'treatment'. We see all of our work, whether as partners or separately, as providing a continuum of support for service users, their families and communities. Integrated working is most definitely the way forward, and shared working between agencies and sectors needs to become more established in order for this integrated work to be effective. We also believe that joint commissioning would be both a sound way to achieve real economic efficiency as well as provide more opportunities for shared services and

practices. Ultimately, any developments must ensure that the experience of the service user is a good one.

However, there are structural changes required in order for all of the above to be possible and we appreciate that the PHA and its partners and stakeholders cannot bring this about in isolation. We know that the PHA does see part of its role as linking up government departments and strategies, which we acknowledge it is already doing. Our recent experience of the 'Future Search' event was a positive one and the conversation demonstrated that there is will and commitment to join up strategies, budgets and commissioning processes. We welcome this development.

We agree with the principle in the framework that individuals and families should have access to similar services regardless of where people live. We sincerely hope that this is achieved as far as possible, and the regional approach will need to be paramount in trying to achieve this, whilst still acknowledging particular local needs, such as those of rural communities, inner city, high deprivation areas and others.

In preparing this response we have included the views of the Partnership Board, CEOs and Service Managers responsible for all of the services that we deliver together.

Before discussing the detail of the framework, we would like to emphasise four key messages:

- **There is a lack of consistency around the services to be commissioned locally and regionally.**
- **There is a lack of local evidence based practice considered within the framework.**
- **Opportunity Youth and ASCERT believe strongly that joined up working needs to be prioritised by all sectors, both top down and bottom up. The framework should acknowledge the need for a phased approach in areas where progress has been slow – such as joined up working across all government departments, integrated working between statutory and voluntary services, and workforce development.**

Section One: Children, Young People and Families

1. Education and Prevention

We welcome the regional commissioning priorities but believe that these are somewhat limited. Within the context of drug and alcohol education and prevention, family based programmes should include opportunities for young people who are about to become or who are new parents themselves to benefit from targeted programmes aimed at their personal development. The Strengthening Families programme is currently delivered with little coordination time. We would urge the PHA to consider these aspects before commissioning such programmes. There is a great need for developing more work in schools; we would like to ensure that this works across both primary and post primary education, including Alternative provision. Again, programmes will have to be sufficiently flexible and adapted to meet the needs of individuals and groups within these settings. Currently collaboration between government departments and in particular with Education, requires a lot of improvement. Joint commissioning between PHA and DE will have to be phased development.

There is conflicting evidence about the effectiveness of life skills programmes for young people. We believe strongly that any education and prevention programme with young people needs to be developed within the context of the current economic climate in Northern Ireland. The link between the development of life skills and opportunities for education, training and employment, are well established. Young people aged 16-19 represent 6%, just over 100,000 of the NI population. Of these over 13,000 (13%) are not in Education, training or employment.(Scoping Study DEL 2011). If we look at the aged 18-24 population recent figures suggest that 34,000 or nearly 20% of this group are not in education, employment or training in NI (NERI 2013). The more vulnerable groups within this population are those where the NSD and Commissioning Framework need to have an impact. Therefore, we cannot underestimate the range of vulnerabilities and risk factors affecting this group. Generational unemployment and poverty also has affected families and so family work and targeted work with children and young people needs to be multi-component as well as work alongside other strategies, such as NEET.

Prevalence of Alcohol & Drug Related Harm in NI (all the statistics are according to the DMD, YPBAS & Census of Treatment Services) which are not always reliable. The evidence from The Regional Impact Measurement Tool (which unfortunately is not mentioned within the Commissioning Framework document) should also be included. According to the Targeted Education Service RIMT there has been a substantial improvement in knowledge from those attending education programmes. We believe that this allows the young people to reduce harm and make a healthier choice; there is a significant change in attitude around getting help for an alcohol and drug problem plus a reduction in drug and alcohol use from young people while attending the programme with 86% saying that they have no intention of using drugs in the future.

The Framework fails to acknowledge the needs of young people with Learning Disabilities, those attending AEP (Alternative Education Programmes) or those living within TSN areas. Also those living within the care system are not mentioned as a vulnerable group and yet 1 in 20 looked after children have been identified as having a substance misuse problem. The current

Targeted Education Provider (SSE49) has worked with approximately 889 young people from several Alternative Education Projects within the EHSSB over the last 4 years. Those disengaged from schools and who are attending Alternative Education Programmes should also be recognised as a vulnerable group. The Targeted Education Service has delivered over the last 4 years 29.5% of its training to AEPs.

Point 7.2.2 of the document states: 'Alcohol education is misleading and should be replaced with 'prevention''. We would argue that the two are different and one should not be replaced with the other. While we recognise the successfulness of evidence based prevention programmes - we must not lose sight of what these do not address and of what age group they do not work with.

Commissioning of services will take into account value for money yet Strengthening Families is the only suggested family programme – This is probably the most expensive programme with only 10 families benefiting each round of (taking 3.5 months). How many of these programmes will the PHA realistically fund – with each programme costing approximately between £15,000.00 and £20,000.00? Other models should also be considered. For instance, the Oxford Brooks model which is also evidence based and only 7 weeks substantially reducing the cost. It may be restrictive to consider only one model for the purpose of commissioning.

The Good Behaviour Game also only works up to the age of 14 and is a parent and child programme – The programme includes students and parents element. The pupil element consists of 12 one-hour units delivered weekly by teachers at the participating schools. The programme includes 3 day education/training of teachers and social pedagogues who deliver the programme in schools, as well as supervision. Other programmes include The Seattle Social Development Project which works up to the age of 12 – again focusing on the onset of drinking and engagement in risky behaviours and the STARS programme focusing on abstinence.

'Support effective delivery of alcohol and drugs policies and social norm approaches in schools through joint working/commissioning with DE/ELBs' point 7.8 of the document. Our concerns would be that the evidence based programmes mentioned within the framework have not been incorporated into the PSHE education framework – time is needed for this to happen and to be adopted by all schools. In addition it is putting a lot of onus onto the school to facilitate the programmes. Will they be sufficiently equipped to do this? How will they access the training especially if they are not mandated to attend?

Service Aims

The framework highlights one particular service aim as 'the environment in which young people live should support a delay of/decrease in their consumption of alcohol/drugs. (Page 24). We believe that this is an overarching aim and it may be difficult to quantify its success. This may need to be made more specific for commissioning purposes.

Outcomes

While we accept that prevalence and attitude surveys will help to measure the outcomes listed in this section (page 24), we also believe that for more targeted programmes, such as Strengthening Families or life skills programmes, we should be measuring progress against improvements in family relationships, parenting skills and resilience amongst children and young people with regard to coping with difficult situations. The behaviours of vulnerable children and young people with regard to drugs and alcohol will be different than those of children and young people in general. We also need to acknowledge the extent of poly substance use amongst young people in particular, so it is not always possible to measure harm reduction specifically with regard to alcohol or drugs when a variety of substances are in the mix. Education programmes need to allow for this.

2. Early Intervention and Treatment

Regarding the development of locality planning groups and family hubs, to address early intervention, we welcome this and see it as an example of integrated working. However, for those at their most developed point, such as in the Northern Trust area, all of their work is based on good will of agencies and groups, resources committed in kind and coordination done by people who are doing this on top of their 'day job' – there are no infrastructure resources attached to this development at all! With regard to children and young people, the 'shared care model' of early intervention and treatment needs to be developed in practice between statutory and community and voluntary services .until there is true partnership between sectors, the fully integrated working will not happen.

The regional priority for ensuring a specialist DAMMHS service in each CAMHS is welcomed. However, this should be in conjunction with aligning community based providers/services in order to address all steps in the stepped care model and all tiers in the NSD. If a DAMMHS is set up in line with the current Belfast Trust model, this will not be sufficient to ensure integrated working. While we appreciate the changes already taking place within CAMHS and the developing openness to working collaboratively with community and voluntary services, this is still in its early stages. Young people still need to be able to self-refer or via a range of support networks and this is not currently possible. The informal nature of voluntary sector services is highly valued by clients and important to their engagement.

In developing a commissioning model for treatment services, we agree that treatment is one part of a 'stepped care' or 'tiered' process. In order for all of us to be truly 'person centred' it is difficult to see 'treatment' in isolation as service users need to be able to easily access all levels of intervention depending on what they need at any particular time.

Common screening and assessment is a valid way forward, but the experience of RIAT so far is that its development has been sporadic and it will take a long time to get to a point where it would be used effectively across sectors. We hope that there will be a clear development plan for this work.

'Commissioned specialist youth treatment services should be required to build links with children's services to facilitate referral between the agencies and to provide support to children's services in increasing their capacity to respond to lower risk substance misuse

among children and young people' (page 28). We believe that this is a significantly ambitious expectation given the current situation between services. We also would like to clarify if this refers only to specialist statutory services or would this also include commissioned community based services? We need to acknowledge that the range of expertise and skills within the voluntary providers is at least equivalent to those of the statutory sector, and in some cases, more qualified and experienced.

The current community based treatment programme (DAISY) provides a multi-component treatment model for young people ages 8-21 (and up to 25 in West) who are misusing drugs and alcohol as well as those who are affected by parental misuse. Keyworkers provide a number of therapeutic and psychosocial interventions with young people who could be defined as having a 'Tier 2' drug and/or alcohol problem. These include motivational interviewing, brief intervention, building resilience, diversionary activities, and well as creative therapeutic approaches such as the use of art and play therapy.

Those cases assessed at Tier 3 are referred to specialist therapeutic interventions include specialist counselling (BACP registered) and systemic family work.

In the last 4 years, DAISY has developed systemic family work as the core specialist therapeutic approach within its model. Understanding and working to change not only the young person but also the context within which the drug/alcohol issues have developed and are maintained is fundamental to the DAISY model. All DAISY practitioners have attended a number of training days in systemic practice and attend regular systemic consulting sessions about their cases. As part of this approach, all cases are offered 'unstructured' family support, and Tier 3 cases are assessed for and offered systemic family work if it is appropriate.

Evidence Base for Family Therapy

Alan Carr (2009) provides us with a comprehensive evidence base for Family Therapy as one of the leading approaches for adolescent substance misuse. In a systematic review of fifty-three studies of the treatment of adolescent drug users, Williams and Chang (2000) concluded that comparative studies consistently showed family therapy to be more effective than other types of treatment. In three systematic reviews covering thirteen controlled trails of family therapy for adolescent drug abuse, Liddle and his team (Liddle, 2004; Ozechowski and Liddle, 2002; Rowe and Liddle, 2003) concluded that for a significant proportion of young people, family therapy was more effective than routine individual or group psychotherapies in engaging and retaining young people in therapy, reducing drug use, and improving psychological, educational and family adjustment.

Carr, A. (2009)

Williams, R. and Chang, S. (2000) A comprehensive and comparative review of adolescent substance abuse treatment outcome. Clinical Psychology: Science and Practice, 7: 138-166.

Liddle, H. (2005) Multidimensional Family Therapy for Adolescent Substance Abuse. New York: Norton. A version of this book is available at www.chesnut.org/LI/cyt/products/MDFT_CYT_v5.pdf.

DAISY currently supports families, but only where the young person using substances is engaged. However if the young person chooses not to engage in treatment, carers and other family members can only receive limited support. This will usually consist of 1-3 sessions that would focus on education and information about alcohol/drugs and support to promote effecting coping behaviours.

Those families where the young person is engaged in the service can avail of longer term family support. Providing support and/or family therapy for the family not only helps the family cope, but can indirectly have an impact on the family member who is using.

We welcome the reference to holistic work with children and young people and encourage commissioners to account for this in all tendering specifications.

'The service should be accessible to young people with a diverse range of needs (including Section 75 groups), in terms of its physical location, opening hours and having a range of gateways through which young people can access the service (including self-referral).' Page 32
Does this relate to all treatment services, including CAMHS/DAMMHS? How would self referral work?

'Counselling' is referred to at various points – including in the care pathway on page 33. Appendix B outlines expectations for support staff. However, the term 'counsellor' is used generically and we need to be reassured that it is not the title of the practitioner, but the ability to do the job based on commonly agreed standards, that is important.

On page 20, reference is made to ensuing 'clinical supervision' for all practitioners in treatment services – currently contacts do not allow for this, except for 'counsellors. Can the PHA ensure that provision is made within specifications for this resource to be included?

While we agree that we must take account of 'research validated' evidence based practice, we must also take account of a combination of local, regional and wider 'practice based' evidence. If we overlook this the voice of the service user may be missed.

NSD tiers and mental health steps are not co-terminus – this needs to be addressed if we are to ensure a clear relationship between substance misuse and mental health services.

The target population is 11-17 as seen on page 29. Opportunity Youth and ASCERT are keen to know if this age range can be extended in practice as is the case now? We are currently working with children as young as 8 and up to 21, and in DAISY West up to 25 years. There is also the issue of transition from children to adult services where age thresholds vary across services. What are the plans to address this?

Services for young people with co-existing conditions – i.e. substance misuse and mental health issues are now operating within the voluntary sector. Is there an intention to keep this service within the CAMHS remit under this framework?

Regarding transition to adult services and planned transitions, while this is the ideal outcome, the work required to get services to this point, cannot be underestimated. This needs to b addressed through a multi agency development plan, also requiring resources. With regard to experience of working with young people, many of them move in and out of services across their teenage years and in many cases they may not be assigned to any particular service when they come to us. For instance, we have young people who have been involved with CAMHS but may not be on their register when they come to DAISY. If they are over 18 we then have to help them to engage with adult mental health services without any transition planning. There should be a transition support system between children and adult services, whether mental health or substance misuse, especially when many young people 18+ are unlikely to cope in adult systems.

We note that the framework still does not address the homelessness and housing issues of young people. Accommodation and homelessness issues for young people with substance misuse issues are significant in our experience, and well documented in various strategies, including C&YP 10 year strategy. While we recognise that there is currently insufficient expressed demand for residential treatment services for young people, there is demand for appropriate supported housing, both temporary and permanent for young people who are unable to live in hostels or mainstream rented accommodation without significant support. We would urge the PHA to discuss possible developments in this area with DSD and Housing Executive; the homelessness strategy is currently under consultation so timing is right for these discussions. In addition, housing agencies should be brought into the fold so that more collaboration might be possible. We can envisage partnerships between substance misuse services and housing services where the expertise of each is brought together for the benefit of the young people requiring treatment and accommodation combined.

The goal of youth treatment is to provide community based support. However, there are occasions when parents are not able to cope with their young person's behaviour, in spite of intense therapeutic input. Generally, the options available to young people are secure accommodation such as Lakewood, but this is not a drug rehabilitation unit and cannot always provide effective support for young people and families coping with chronic drug and alcohol problems. An alternative is definitely required – safe and supportive housing where specialist work can take place with the young person using.

ASCERT and Opportunity Youth welcome the idea of a common assessment framework for both substance misuse and mental health services. There should be a commitment required from all commissioned groups in the new tender round to participate fully in developing this. This needs to be approved at senior level in all organisations.

Hidden Harm

The commissioning priorities need to include youth treatment services too for those young people who themselves are parents or are about to be. There is a significant incidence of young men in our services who are fathers or father to be. Work needs to be done with them and their partners regarding potential harm to their children.

The increase in hidden harm cases across both DAISY East and West in the last year in particular indicates a need for a regional approach to support services, not just a local one. We would like the PHA to look into this further.

We also need to acknowledge that those children and young people who are affected by parental misuse are at high risk of misusing themselves. Therefore there needs to be an understanding that youth treatment services have a hidden harm element as many young people will be falling into both categories. To commission hidden harm services separately may lose the experience and expertise already available within youth treatment and support services.

Family support and family therapy which takes a systemic perspective is also shown to be effective in this area. The commissioning framework needs to ensure that family work is part of the actions to address hidden harm issues. The Steps to Cope model for instance, is already in place and should be rolled out further.

One area that is continually overlooked when assessing the impact of parental misuse, is kinship care. There are many kinship carers looking after grandchildren, children of siblings, who get little support in developing their own coping strategies. According to the Fostering Network, 'around 30 per cent of the 2,500 children and young people in care in Northern Ireland now live with family relatives in a formal kinship care arrangement, a 53 per cent increase since 2009. According to Dr Leslie Ann Black in Feb 2012, an additional 8,000 – 10,000 children are living in 'informal' kinship care situations. It is estimated that up to 60% of parents have substance misuse issues, resulting in other family members taking care of their children.(Buttle Trust 2011). This is in addition to the 70% of 'looked after children' who have parents with substance misuse issues. This are also needs to link up with Carers UK; in particular young carers' projects and provision needs to be made for work in this area.

Section Three - Capacity

Service User involvement

We believe that the model proposed for adult service user involvement many not be appropriate for children and young people. We need to be creative in how we involve them. We hope that the PHA will consider proposals from youth support services to enhance service user involvement; DAISY is currently developing peer group work amongst young people who have been through the 1-1 programme. It may be helpful to discuss the progress of this as part of the tender specifications.

We do not believe that the model pro[posed in the framework is the only one available to us, in particular with regard to seeking service user views. This could possibly be a dedicated worker across all services to keep a link Service users can be encouraged to help design surveys – such as through Survey Monkey. Peer education and support programmes, can also be accredited – this is especially attractive for young people trying to build up their CV.

Workforce Development

Throughout the Commissioning Framework document, we are concerned that some initiatives will require more development time than others. We need to address this through a phased

programme – such as the overall integrated approach; this will require a development plan, recognising that while some initiatives could begin on 1/4/13 (such as services currently in operation), others will require significant capacity building and lead in times (such as integration of specialist CAMHS).

From our work it is clear that the workforce development needs are still significant. While the substance misuse awareness training has been very well taken up over the last four years in the areas where this is available, there are still many practitioners across the region who require an improved understanding of substance misuse, including hidden harm issues. There are some developments, such as that within the Youth Justice Agency, to ensure that all practitioners have the ability to support young people around substance misuse issues (at least up to Tier 2) and incorporate this into their day to day practice. However, this is piecemeal. As with the issue of young people not in education, employment or training (NEET), it needs to be everybody's business, regardless of our specialist roles. Workforce development requires further investment. We hope that all of the commissioning priorities will take account of the relevant workforce development needs.

At no point in the Commissioning Framework can we see a definition of the core competencies required to carry out the work. Unless we have these we are not clear about the standards to be achieved across all providers. For instance the DANOS competencies have not been mentioned. Is there a plan to define the qualifications, skills and experience required to be a Drug and Alcohol specialist worker?

Final Comments

The Impact of Alcohol programme of funding from the Big Lottery has a three and four year cycle. This will hopefully be a useful period to establish how we address this issue through the funded projects, both local and regional ones. We believe that the PHA and Big Lottery need to work closely together to ensure that the outcomes are monitored and successful initiatives used as evidence for mainstreaming programmes going forward

In conclusion, we recognise that all of the above is not the specific responsibility of the PHA and/or the HSCB. However, we believe that you can be champions for 'real' integrated working and joint commissioning and we are committed to having an active part in this. We are not discounting the element of competition which exists between services for resources, in particular across the community and voluntary sector; however, we strongly believe that it is possible to deliver services in such a way that young people and adults can benefit from a more 'one stop' approach to meeting their needs.

We hope that you find this helpful and we are happy to discuss any of the above comments more directly with you at any point during the consultation period.