Response to the Alcohol and Drugs Regional Commissioning Framework

Representatives of the Independent Sector Forum, having met on two occasions to discuss and formulate a response to the proposals set out in the Alcohol and Drug Commissioning Framework for Northern Ireland 2013 – 2016. We would ask that the following points be noted and given due consideration, as the framework for commissioning of alcohol and drugs services in Northern Ireland takes shape and is further developed.

As a whole we support the intentions of the commissioning framework as a model for the shape of drug and alcohol services that should be pursued over time, but that is not actionable in 2014. Some commissioning priorities such as the commissioning of lifeskills programmes for young people, joint working/commissioning with the DE/ELBs, commissioning of a specialist drug and alcohol service within CAMHS and interventions targeting people in the criminal justice system are ambitious and will take time to take forward. Intentions to develop the workforce in Tiers 1 and 2 settings to provide brief interventions and the implementation of the RIAT assessment tool for young people are other areas that will take time to develop.

We are concerned that local services commissioned in 2014 will exist within an overall model of services that are incomplete, therefore we suggest that the commissioning process should take account of existing delivery models and reflect a transition towards aligning services to achieving the ambitions of the framework over the 3-5 year cycle.

Evidenced programmes

We have a fundamental difficulty with the documents focus on evidenced programmes. The PHA has ignored the breadth of experience and models of delivery that are already in place in Northern Ireland. This is unacceptable. The focus appears to be on replacing existing practice with specific programmes that have been researched, regardless of their cultural appropriateness for delivery in a Northern Ireland context.

A reliance on specific evidenced programmes that have been developed in other countries is short sighted and will be more resource intensive than necessary. The framework document itself recognises that these programmes require additional research if used in Northern Ireland yet it does not define how this would be achieved. The PHA has ignored local practice and their approach will stifle local innovation. We argue that it would be more beneficial to invest in supporting service models that are informed by evidenced practice and to invest in greater evaluation of these over the life of the commissioning cycle.

Children, Young People and Families

It is agreed that educative and preventative initiatives and programmes across the sector are a laudable goal, though it is felt that such initiatives and programmes should also provide fluid pathways into appropriate and specialist intervention services for children, young people and families when such services are required.

Community based services

We support the commissioning priority for an integrated prevention strategy across multiple settings which would co-ordinated by a Community Support Service however the delivery of prevention services should not be the responsibility of the service. There is a need for a regional universal prevention programme for schools but this should be supplemented by local commissioning of targeted programmes for young people at greater risk or who are using substances. This would provide a level of targeted, harm reduction focused intervention for young people that would support those that are not ready or suitable for treatment and build a continuity of services between prevention and the drug and alcohol treatment services.

The Community Support Service should not be focused on service delivery. It should co-ordinate a prevention strategy between providers to meet community needs and seek to improve access to services. It should lead the development of capacity and local action within communities, and it should focus on driving down drug and alcohol health messages into and through communities.

It is strongly suggested that community based mobilisation should aim to increase awareness and access to services and that services are clearly delineated – for instance through a pyramid model of provision from broad base to the narrower apex – in order that community mobilisation is appropriately targeted.

Youth Treatment Services

We disagree with the proposal that youth treatment services should only work up to the age 17. Some young people are not appropriate for adult services at age 18 and we propose that the youth treatment services should be able to provide services to up to the age of 21 or 25 and support the transition into adult services if appropriate.

Youth treatment services should also be able to support families where the young person is not willing to engage in treatment, as the parents or siblings have needs that can be supported.

Youth Treatment services should also have a role in providing support for young people with co-existing mental health concerns where they may not be appropriate for referral to CAMHS or where the capacity may not exist in CAMHS to work with them.

Adults and the General Public

Adult services should be developed in order to meet the needs of a diverse range of service users, with programmes of intervention ranging from: education, guidance and advice, brief interventions, through to, medium and longer-term counselling and psychotherapeutic intervention in the case of complex and enduring substance misuse and dual diagnosis patients/clients.

In relation to families, the framework should include the provision of support for family members in their own right, regardless of whether the drinker or drug user is engaged in treatment.

Capacity

Workforce capacity and workforce capabilities should be developed sensitively, allowing the appropriate time to train, develop and extend the abilities of staff, including in terms of professional registration and the attainment of critical skills. The commissioning framework is heavily dependent on workforce development, yet there is no reference to developing competency. Without a competency based approach it is unlikely that employers will embrace the model and we run the risk of training practitioners across tiers to assume responsibilities that they are inadequately trained to deliver effectively.

Other

Discussions are required to take place with BIG in an effort to ensure the additional funding created by the Impact of Alcohol (IOA) Trust and regional programmes are considered within the framework.

Consideration should also be given to services which would best suit a regional model of delivery moving forward.

In conclusion we would strongly urge that those services with many years of expertise in the substance misuse field, and who have detailed knowledge of both regional and local needs, in terms of the devastation caused by alcohol and drugs throughout communities are intimately involved in the planning, development and delivery of services, going forward.

On behalf of ISF

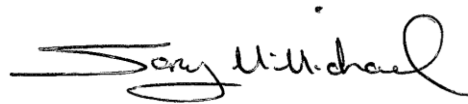
Ms. Anne Bill Director Forum for Action on Substance Abuse and Suicide

Signature

Ms. Anne Marie McClure Chief Executive Officer Opportunity Youth

Signature

Mr Gary McMichael Director Action on Substances through Community Education and Related Training (ASCERT)

Signature 

Mr Alistair David Sweet Head of Clinical Services Addiction NI

Signature ***A. D. Sweet***

Dated: 15th April 2013.