



# Alcohol and Drug Commissioning Framework for Northern Ireland 2013-16

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Consultation Response

April 2013

## Introduction

1. ASCERT is a charity operating across Northern Ireland providing services that address alcohol and drug related issues. ASCERT provides prevention, intervention and training services to around 8000 people in Northern Ireland each year.

## Overview of our response

- 2. We recommend that the framework should set the direction for development of an integrated model for drug and alcohol services, but that the services commissioned in 2014 should represent a transitional model that builds on existing practice, closes gaps and promotes greater integration. The PHA should set specific outcomes with timeframes partnership arrangements at regional and local levels to enable a co-ordinated joint commissioning approach post 2016.**
3. We are very concerned that the framework represents a vision of a model for drug and alcohol services that is highly ambitious and aspirational. It is built on a premise of partnership arrangements between health and other departments and agencies that are not in place and a change in culture around service delivery models in the public sector that will take time to develop. It proposes the replacement of existing practice with external programmes and methodology that is untested in Northern Ireland.
4. Despite this the PHA will restructure all of its drug and alcohol services through commissioning this year based on a model where key components needed to make the model work are in place. In our opinion this will ensure that some of the frameworks outcomes cannot be met and we will have a model of drug and alcohol services that is less integrated and less effective than currently exists.
5. It is certain that the needs of some people affected by substance misuse will no longer be met, as services will be lost if the shift in responsibilities for commissioning and the changes in delivery models in non-specialist services the framework indicates are not delivered.
6. The framework has focused on practice guidance and research elsewhere in the UK and further afield, without proper consideration of the Northern Ireland context, the organisational culture within the public sector or the experience of existing services.
7. The framework as it stands does not acknowledge or plan for the difficulties faced in delivering the changes it promises. Specific examples include;

8. The intention to have the department of Education and ELB's take on responsibilities for commissioning of universal prevention, that are unlikely to happen in the lifetime of the framework as partnership arrangements to take this forward don't exist.
9. The proposals for a more integrated pathway model for young people's treatment young people depends on the development of specialist CAMHS services, which will take time to develop.
10. The model is based on an expectation that early intervention will be assumed primarily by practitioners across Tier 1 and 2 organisations, but this will require a fundamental shift in organisational culture in the public sector and extensive workforce development over time.
11. The framework claims to aim for 'improved understanding of what works and commissioning of services better informed by evidence based practice', yet has ignored local experience and practice. It is curious that the PHA has totally failed to consider the evidence from local services and in particular its own outcome measurement the Regional Impact Measurement Tool that all commissioned services complete. The framework focusses on evidenced programmes, rather than evidence based practice. We would argue that services currently being delivered in Northern do reflect evidenced based practice, using approaches that are known to work.
12. There is an aim to integrate the HSCB and PHA commissioning plans and priorities and themes that include partnership working, integration of care pathways, but the priorities at a regional and local level do not outline the extent to which partnership has been developed or a timeframe for implementation. Regional commissioning priorities relate to partnership with Education and Justice but there is no indication that this commissioning will take place as there is no agreement that they will take on these commissioning responsibilities. The result is likely to be that key elements of the overall model for drug and alcohol services will not be in place in 2014, and some services that already exist and are commissioned at a local level will end because of an expectation in the framework that those areas of work would be taken forward elsewhere.
13. The framework is blatantly contrary to some of the NSD principles that it references on page 10. A principle is that 'Commissioning of services takes account of and builds on the services already in place'. We are deeply concerned that the existing services and models of practice have not been considered or referenced in relation to the framework and the evidence of impact of local services has not been considered.

14. Another NSD principle is that 'Commissioning of services to address alcohol and drug related harm is based on a commitment to take action informed by evidence about the problems are, what works, and by information on cost effectiveness.' Not only has the framework ignored local practice it has failed to speak to the issue of cost effectiveness at all. On one hand it cites specific evidenced programmes yet does not say anything about their cost effectiveness or the implication on volume of beneficiaries supported in comparison to existing models. If it did, we predict it would find that the impact of implementing many of the programmes cited would cost more and reach less people.
15. The document also refers to challenges to taking evidenced programmes that have been developed mainly in the USA and their cultural relevance to Northern Ireland and that implementation here should involve evaluation and research, yet there is no intention on the part of the PHA to provide such evaluation.

## **Young People Children and Families**

### Education and Prevention

16. We agree that there should be a Community Support Service, however we are concerned that insufficient consideration has been given to the scale of resources required to perform the functions proposed. There should be more specific detail on the activity this service should undertake, as if it were commissioned at the level of the existing community support services, it would not be viable. It should also be recognised that in some areas there are additional local contracts in place to provide prevention, targeted education and capacity building programmes. If the intention is for the Community Support Service to absorb these areas of work it will result in less delivery to beneficiaries, as these represent high volume services at present.
17. We support the commissioning priority for an integrated prevention strategy across multiple settings which would co-ordinated by a Community Support Service, however the Community Support Service should not be focused on service delivery. It should co-ordinate a prevention strategy between providers and partners to meet community needs and seek to improve access to services.
18. 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 through a communication strategy.

19. Short bespoke programmes and awareness raising are appropriate, but the Community Support Service would not have the capacity to meet need in all settings. The high volume of demand and need in relation to prevention and targeted education would distract the attention of the Community Support Service from its co-ordination role and from where it can provide specific added value in relation to promoting social change through community development/mobilization and communication and media strategy.
20. There is a need for a regional universal prevention programme for schools but this should be supplemented by local commissioning of targeted programmes for higher risk groups e.g. Young people who are NEET; in alternative education; have learning difficulties; have behavioural issues, that are sexually active; that live in TSN areas; who are at an early stage of drug and alcohol use; are in contact with the police;
21. These are all groups of young people that should be targeted with programmes that *include* a life-skills approach, may be harm reduction in approach and may include accredited opportunities for development. In the last year in the eastern area the PHA funded targeted education service delivered 528 sessions to 930 young people from the categories above. 57% were using alcohol and 18% using drugs and 32% had been drunk in the past month. Post programme there was an overall reduction in the intention to drink or use drugs and the frequency of use.
22. This service is oversubscribed, and its outcomes indicate there is a sizeable population of young people, who are at a higher risk or are already using, that need more than universal school based prevention programmes but may not be appropriate for treatment services.
23. We believe there must be a specific targeted service in each Trust area to meet these needs. This would provide a level of targeted, harm reduction focused programmes 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.

#### Youth Treatment Services

24. 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.

25. 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.
26. The model for youth treatment proposed is based on a premise that Tier 1 and 2 services will have the skills and capacity to provide brief intervention and that the youth treatment services will work primarily with young people at Tier 3. We are supportive of this approach but it is aspirational, as strategically driven workforce development, organisational cultural change and a change in the role of children's services is required to achieve this over time. Youth treatment services should work with young people and families at Tiers 2 and 3. This is also important to allow the clients choice in relation to how and where they access treatment.
27. Youth Treatment services should 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.
28. 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.
29. 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.
30. The document highlights a number of psychological therapies, including CBT, Motivational Enhancement Therapy, Relapse Management Therapy and Family Therapy. However there is no detailed evidence base included to support what has actually been found to be helpful for young people misusing alcohol/drugs.
31. 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 including individual therapy (including CBT), therapeutic communities, out-ward bound programmes and the 12-step Minnesota model programmes.

32. In three systematic reviews covering thirteen controlled trials 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 youngsters in therapy, reducing drug use, and improving psychological, educational and family adjustment. Carr's summary and review suggests that services for adolescent and drug and alcohol misuse should involve an intensive family engagement process and thorough assessment, followed by regular family sessions over a three to six month period, coupled with direct work with young people and other involved professionals. The intensity of the therapy should be matched to the severity of the young person's difficulties.
33. 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.
34. We welcome the reference to holistic work with children and young people and encourage commissioners to account for this in all tendering specifications.
35. '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.
36. On page 20, reference is made to ensuing 'clinical supervision' for all practitioners in treatment services – currently contracts do not allow for this, except for 'counsellors. Can the PHA ensure that provision is made within specifications for this resource to be included?
37. 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.

38. 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.

#### Hidden Harm

39. The framework suggests that adult and children's services should have arrangements in place to support young people affected by hidden harm, however we feel that inferring responsibility will not make it happen. It is our opinion that there should be a plan in place in each locality, co-ordinated by the DACT and the Children's Outcomes Group to ensure that a range of supports are available to children of all ages, individually and for family units that can provide appropriate levels of support.

40. It should also be recognised that some young people may not wish to identify themselves to services or have access to support. The framework should specify that age appropriate information and self-help literature and resources should be available to young people and families, and make use of technology based communication methods familiar to young people.

41. The hidden harm agenda depends on the development of the workforce at each tier and a range of settings to provide different levels of support to young people and families. However, this is not reflected in the workforce development section of the framework, which indicates only training on the protocol.

### **Adults and the General Public**

#### Education and Prevention

42. Our views of the role of a community support service are as outlined in the children, young people and families section.

43. We agree there should be a co-ordinated prevention strategy and that the Community Support Service should take that role should not include the direct delivery of structured programmes, instead other providers should



be commissioned to do this, so that the Community Support Service is not distracted from the co-ordination, mobilization and communication functions.

44. There should be structured capacity building training within the community for the general population, volunteers voluntary sector staff that is distinct from workforce training. This should accredited training. More than 600 people across the Eastern area choose community based training programmes to build their awareness and capacity. This is in addition to the workforce programmes available or the bespoke short sessions provided by the community support service. If the Community Support Service were to have to adopt the responsibility for these structured programmes it would divert it from its other roles.
45. 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.
46. 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.

#### Workforce Development

47. 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.
48. Unless sufficient resources are aimed at the skilling up of the entire relevant workforce (i.e. those who have 'client' contact), who primarily sit at Tier 1 or Tier 2 but whose sole role is not a drug focused one, then we are moving backwards in terms of again potentially causing a blockage at Tier 3 due to upward referral of inappropriate clients whose substance use/misuse does not meet the threshold of Tier 3.
49. The proposed WFD model reflects a range of core training and development needs of the main sectors and roles. It should also include training on

providing support to children living with hidden harm, and developing skills for working with families, included systemic practice.

50. The scale of the need for workforce development is immense and we are concerned that resources will be made available to actually deliver on the proposed programme. Whilst training for Adult Treatment services and Low Threshold services need intensive and higher level training and development there are comparably few practitioners who fall within this subsection. The implications for all sector mental health, targeted populations BI and extended BI, Hidden Harm and Youth work services are a huge undertaking – these are very necessary and we advocate their inclusion within the framework however PHA/HSCB must be aware of the scope of this undertaking in terms of resourcing, and on-going training requirements due to turnover of staff across these roles/sectors
51. We are concerned about whether the PHA can mandate training across sectors not directly related to it, e.g. Youth service, PBNI, voluntary & community etc. where large numbers of the staff who need this development will be employed. This is already reflected by the lack of uptake for the regional training for BI within primary care, under the LES agreements. If the HSCB cannot inspire it's GP's and practice nurses to undertake training in something that a) their practice signed up for b) is evidence based and c) is a key focus within this framework how will the training of much of this training, especially alcohol brief intervention happen.
52. This also links to the final Regional Commissioning Priorities in terms of what services should ensure they have in place to effectively deliver competent evidence based practice. How can this actually be checked, implemented, monitored and ensured? It certainly cannot be asked of any WFD service provider to look to undertake this, therefore how will the 5 priorities outlined in in the framework be met?
53. Relating to funding available, are PHA aware that some of the mandated evidence based interventions have a limited trainer base in NI, and as such the cost of providing this training is likely to be substantial as it will necessitate the buying in of trainers from UK/abroad, or using locally qualified consultant (e.g. for MI training). If these courses are to be mandated as necessary within Adult treatment consideration needs to be given to how these will be funded – and will specific providers for individual courses be commissioned centrally to ensure quality management and standardisation of practice?

### Family Involvement

54. We agree that engaging families in the support and treatment of drug/alcohol misusers is important both as a support to the family member as well as to help the family member to engage and progress in their treatment. However, there is a lack of provision of support for family members in Youth Treatment services where the young person who is misusing alcohol and/or drugs misusing does not want to engage in services.
55. DAISY currently provides both family support and family therapy for young people and families impacted by substance misuse. However if the young person chooses not to engage in treatment, carers and other family member 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. 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 using.
56. There is also a lack of a 'respite' services for family members who have a young person who is misusing to the extent that it is having a negative impact on the family, and in particular on younger children in the home. 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.

#### User Involvement

57. We support the model for user involvement proposed but as this is suitable only for adult service users, we believe the PHA should commission a mechanism for engaging young service users also.

#### Other Comments

58. 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.
59. Consideration should also be given to services which would best suit a regional model of delivery moving forward.
60. 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.