Alcohol and Drugs Commissioning Framework for Northern Ireland 2013-2016

RESPONSE TO THE CONSULTATION

5th JULY 2013

1.0 BACKGROUND

The Alcohol and Drugs Commissioning Framework 2013-16 (Draft) was prepared by PHA/HSCB to inform future commissioning of PHA/HSCB services and help reform and modernise existing HSCT provision. It is also hoped that this guidance will inform the commissioning of services by other bodies with a role in addressing alcohol and/or drug issues.

The document was drafted in March 2013 and consulted on April-May 2013. This document outlines the key points raised by respondents.

2.0 INTRODUCTION

Fifty-two organisations responded to the consultation. Overall there was strong support for the range of priorities outlined in the Commissioning Framework and for the direction of travel. The report which follows provides a summary of the key trends in the responses received during the consultation and some recommendations about action to be taken or changes to be made to address these.

Each section outlines the responses, provides a reminder of the original priorities and offers recommendations for change to address the feedback. Further proposals to address specific aspects of the work are also included where appropriate.

SECTION 1

3.0 GENERAL ISSUES

3.1 Responses from the Consultation

- Some respondents queried whether or not there is sufficient resource to implement the priorities in full.
- Many respondents commented on the fact that there was too much emphasis given to evidence based practice particularly in the area of prevention and education, much of which originates outside of Europe. The question of

applicability to Northern Ireland was raised. It was felt that equal importance should be given to acknowledging good local practice.

- The document was viewed as being very ambitious and it was felt sufficient time needs to be set aside to develop certain aspects. A timeframe for implementation was suggested.
- The emphasis on relying on a range of professionals to provide education and brief interventions was welcomed. However it was felt that some sectors are not sufficiently trained or resourced to deliver on this agenda i.e. social workers, nursing, and teachers. It was also felt that life skills approaches are not sufficiently established with the Education sector and that establishing these programmes will take time.
- Many felt that there should be a greater emphasis on addressing anti-social behaviour and a greater emphasis on the role that Councils and Policing and Community Safety Partnerships can play in addressing this.
- Some expressed concern that there was little reference to prescribed medication.

3.2 Recommendations on General Issues

It is proposed that:

- HSCB and PHA should be tasked to identify potential sources of additional funding to implement new or additional services identified in the commissioning framework.
- Locally developed good practice, which has robust evaluation, should be considered for funding.
- The Commissioners should draw up a timetable for implementation for those areas of the Commissioning Framework which require a transition phase.
- Workforce development training for front line workers should be frontloaded to build capacity in the first 1-2 years to support the transition to the new models.
- DACTs, in their plans, should ensure that appropriate linkages are made between PCSPs and Councils to ensure a joined up approach to anti-social behaviour.
- PHA/HSCB should continue to work with the DHSSPS to address this misuse of prescription medications at strategic level. Where appropriate,

specifications for services will include action to address misuse of prescribed medication at local level.

SECTION 2 - CHILDREN, YOUNG PEOPLE AND FAMILIES

4.0 EDUCATION AND PREVENTION

In the Commissioning Framework Consultation document there was a section on Education and Prevention in the Children, Young People and Families and also in the Adults and General Public sections. It is proposed that one service be provided which covers all age groups. For this reason the priorities in this section have been combined.

4.1 Commissioning Priorities

Regional Commissioning Priorities for Education and Prevention

Children, Young People and Families

- *Commission evidence-based parenting skills and family based programmes including Strengthening Families.*
- *Commission evidence-based life-skills training for young people.*
- *Support effective delivery of alcohol and drugs policies and social norm approaches in schools through joint working/commissioning with DE/ELBs.*

Adults/General Public Section

- *Public education initiatives on alcohol and drugs (including prescription medication) should concentrate on the following areas;*
  - *Providing information about the risks of alcohol/drugs and the availability of help and treatment to reduce harmful use;*
  - *Supporting existing and new alcohol/drug policy measures;*
  - *Providing access to web-based information and self-help programmes.*
- *Public support should be mobilised for current and new government legislation which reduces alcohol and drug related harm.*

Local Commissioning Priorities for Education and Prevention

Ensure that a community support service is in place to deliver Tier 1 services across the Trust/LCG area. This package will include the following components:

- *Delivery of a three year integrated multi-agency education and prevention plan, in communities, workplaces and educational settings, to raise awareness of the impact of drugs and alcohol locally;*
- *Evidence-based community mobilisation initiatives which will raise awareness and concern about alcohol related harm and support policy implementation and change;*
- *Local media initiatives to raise awareness and increase acceptability of the interventions provided to address locally identified alcohol-related problems.*

4.2 Responses from the Consultation

There was consistency in the responses regarding the need for tier 1 services, and the benefits of more integrated planning, the appropriateness of life-skills methods and provision of Strengthening Families programmes. Many of the responses included commentary on the role of the Education sector in this agenda. There was broad support for establishing locality based community support services though some concerns were raised in relation to the outworkings of the proposed model.

Specific views:

- More clarity is required on how joint commissioning with DE/ELBs will be met. It was pointed out that DE has not endorsed joint commissioning at this point and that building this relationship may take time.
- There was perception of a lack of consensus within Education on the desire for PHA to commission life skills programmes within schools.
- The role that teachers play in the delivery of life skills programmes in schools was broadly recognised. However it was pointed out that there is a need for

staff training and that currently staffing levels within the ELBs could not support this plan (WELB/SELB).

- Strengthening Families was generally found to be a valued model. The main concern was that numbers availing of strengthening families programme will be limited. Coordination is critical and more information was requested on how the programmes will be developed.
- It was recognised that the role of Family Hubs should be considered in the work of the Education and Prevention Service. However cognisance was taken that these are in differing stages of development.
- Targeted drug and alcohol programmes for young people at risk are still needed in community settings, as general life skills programmes within schools may miss these young people.
- Greater clarity on the detail of the community support service regarding role and function was requested. This needs to be resourced at a sufficient scale, and should have a co-ordinating rather than delivery role. It was thought that the Community Support Service should not include direct delivery of programmes.
- The need to reach out to particular populations was highlighted including over 55's, LGBT community and ethnic minorities.
- Work should be on coordination, mobilisation and communication. Greater clarity around community mobilisation was also requested.
- The importance of the Councils' role in prevention through public health, community safety and enforcement roles should be highlighted more.
- Licensed trade need to be involved in regional/local prevention work.
- In the development of a local integrated plan, confusion around provider accountability needs to be avoided, and the process needs to be clear and transparent. Other settings for implementing a prevention plan should be considered such as Housing Departments, Social Security Offices and Higher/Further Education.
- Role of councils in addressing anti-social behaviour and underage drinking needs to be acknowledged more.
- It was felt that there is still insufficient, consistent lobby on alcohol/drugs issues from the NGO sector to Government to effect policy change on issues

such as minimum pricing. It was recognised that it can be hard for Government agencies to undertake this role and consideration should be given to securing such services through the Voluntary and Community sectors.

4.3 Recommendations

Based on the findings it is recommended that the priorities be amended as follows:

1. The priority relating to DE is changed to better reflect their commitment to partnership working rather than joint commissioning.
2. The name 'Community Support Service' to be changed to reflect the range of work this service will be expected to undertake.
3. A regional service to support community mobilisation on alcohol and drug issues.

It is further proposed that:

- More detail is added on the role and function of the Community Support Service (CSS) following consultation with DACTs.
- Role of education sector at both DE and ELB level to be explored further.
- The CSS has both a co-ordination and delivery role.
- Targeted education is clearly defined within the tier one service.

5.0 EARLY INTERVENTION

5.1 Commissioning Priorities

Regional Commissioning Priorities

Build capacity of professionals and front line workers to address substance misuse issues among young people. This will be addressed through the workforce commissioning process to ensure that early intervention services are fit for purpose.

5.2 Responses from the Consultation

There was broad support for the joint integrated approach to early intervention, use of RIAT as the key assessment tool and requests for clear referral pathways. Links to Family Support Hubs were welcomed.

Specific points:

- The role of Family Hubs was identified as a positive resource in a number of responses. It was noted that, at this point, they are not developed everywhere.
- It was highlighted that there is no specific mention of responsibility for capacity building. It would seem that this need for capacity building cuts across HSCB, PHA, Trusts, Children and Young Peoples Services and those commissioned through the NSD to deliver services.
- The document needs to be more specific regarding the responsibility for training on aspects of the RIAT/UNOCINI as well as integrated care pathways and agreed protocols setting out the roles and responsibilities of services and staff.
- A lead-in time will be needed to build capacity. RIAT needs to be rolled out across a wide range of organisations before this model can be implemented.
- It is not clear from the document who is undertaking assessments and screening.
- There is a need for targeted interventions with young people at risk, either on a one to one basis or through group work.
- Substance misuse is an integral part of the work of Youth Justice Staff. This model should be developed elsewhere.
- Once again, many respondents flagged up that transition between child and adult services needs to be addressed for many of these young people.
- There is a need to strengthen the links across prevention, early intervention and treatment and working with the whole family.

- User involvement processes for young people using these services should be referenced.

5.3 Recommendations

Based on the findings it is recommended that the priorities be amended as follows:

1. An additional priority is added – 'Ensure that staff are trained in RIAT' to recognise the need for widespread delivery of RIAT training across services to support the transition to the new model.
2. Training in targeted education on harm reduction should be considered for all staff using RIAT

6.0 YOUTH TREATMENT AND CAMHS

6.1 Commissioning Framework Priorities

Regional Commissioning Priorities

- *Commission the specialist substance misuse within CAMHS services in consultation with local Trusts/DACTs.*

Local Commissioning Priorities

- *Commission community based youth treatment services.*

6.2 Responses from the Consultation

There was support from all respondents for the model outlined.

Specific view:.

- The major issue was the age of transition for young people from children's to adult services. There were concerns about the transition between CAMHS and Adult services, for 17-18 year olds. Services, however configured, should

cater for the age range 16-25 (young adults) to effectively support transition arrangements between children's and adult's services.

- Self-referral to youth treatment services is not included in model/chart.
- Housing options with DSD for vulnerable young people should be considered.
- Mentoring support should be an option.
- While there was support for the model, there was concern that the resource/capacity did not exist to enable CAMHS to deliver the specialist service alone. Some thought there is potential for a greater role for the voluntary sector. *(Some follow-up discussion with the ISF indicated that there was some misunderstanding about the intention of the proposal. In fact it is intended that voluntary sector have a role to play in service delivery in this area.)*
- Some thought the proposal that early intervention becomes the responsibility of tier 1 and 2 practitioners is too ambitious. It will require a culture shift among public sector professionals and considerable workforce development.
- There was support for RIAT, but a concern that it is not yet sufficiently developed to ensure all young people get referred to specialist services.
- Some respondents thought that priority should also be given to the families of young people not willing to attend for treatment.
- Family therapy was identified as desirable key service function, providing a more in-depth and potentially more effective therapy option to complement the shorter term ones currently on offer.

6.3 Recommendations

Based on the findings it is recommended that the priorities for this section remain unchanged.

It is further proposed that:

- the age of transition for youth to adult services be adjusted upwards to take account of the needs of young people

- Need for a culture shift for staff in tier 1-2 to take responsibility for early intervention is acknowledged. This to be addressed under the workforce agenda.

7.0 HIDDEN HARM

7.1 Commissioning Framework Priorities

Regional Commissioning Priorities

- *Ensure professionals know how to respond to both child protection issues and to situations where it is deemed the child is in need of support, as a result of parental substance misuse. (This will be addressed under the Workforce Training Plan).*

Local Commissioning Priorities

- *Commission treatment and support services for young people affected by parental substance misuse and their families, including intensive support for those families most affected, and ensure these services are linked to Family Support Hubs.*
- *Commission initiatives working between adult addiction service and children's services.*
- *Commission initiatives working between midwifery/health visiting and adult addiction services.*

7.2 Responses from the Consultation

Among those who responded there was support for the approach to Hidden Harm as outlined in the Commissioning Framework including multi-agency approaches and the need for good referral pathways.

Specific points were:

- This section should have a stepped care approach as outlined in other areas of the framework. There seems to be an emphasis on the child protection/intensive and less on the brief interventions that show promise in supporting children at a much earlier and more preventative way.

- Ensure that the lower levels of support are in place for parents with substance misuse problems that are below the crisis threshold and therefore not "serious" enough to merit statutory intervention.
- The workforce plan needs to build capacity among the workforce for both child protection issues and provision of support for families whose level of needs does not yet meet the threshold for child protection.
- The role of Family Support Hubs as a referral pathway for early intervention was highlighted in this section with the same caveat mentioned earlier regarding the differing levels of development of the hubs at this time.
- The need for linkages between Hidden Harm and Infant Mental Health work, and between adult and children's services and with these services and schools
- Women who may want to look for help with a drug problem are unlikely to ask for help in pregnancy because they fear the child will be taken off them. More understanding and acknowledgement among staff regarding the value and place of harm reduction messages/intervention.

7.3 Recommendations

Based on the findings it is recommended that the priorities be amended as follows:

1. The single priority to be split into two discrete tasks to give due attention to each aspect of requirements to address Hidden Harm:
    - Ensure professionals know how to respond to child protection issues arising as a result of parental substance misuse.
    - Ensure professionals know how to respond to situations where it is deemed the child is in need of support as a result of parental substance misuse.

SECTION 3 - ADULTS AND THE GENERAL PUBLIC

(For EDUCATION AND PREVENTION see section 2)

8.0 EARLY INTERVENTION - Alcohol Screening & Brief Interventions

8.1 Commissioning Framework Priorities

Regional Commissioning Priorities

- *Ensure that early identification and brief advice programmes are delivered to 10% of the population at risk of hazardous or harmful alcohol consumption in any one year.*

- *Early identification and brief advice programmes should be delivered in the following priority areas;*

— *Primary care;*
— *Emergency Departments;*
— *Maternity Units; and*
— *Criminal Justice.*

- *For any new Alcohol Brief Intervention initiative introduced, the commissioning organisation should commission appropriate evaluation.*

- *Piloting of Alcohol Brief Interventions in other settings should be undertaken.*

Local Commissioning Priorities

- *Voluntary and Community sectors should be commissioned to provide extended brief interventions at locality level.*

8.2 Responses from the Consultation

The need to provide alcohol screening and brief interventions was welcomed by many. The following points were noted;

- People with a learning disability should be considered as a potential priority group for the delivery of brief interventions.
- Each HSCT should develop a strategy for the delivery of brief interventions across all programmes of care.
- Dedicated training services are needed in this area to coordinate and target work more effectively and a clear timetable for the delivery of ABI's needs to be developed.

- Screening and ABI's need to be indicators within QOF to promote uptake of ABI's in primary care.
- NIMATS and the regional Maternity Hand Held Records should be reviewed and updated.
- Concerns were raised about maternity staff having capacity to undertake screening. The need for dedicated posts within maternity to undertake BI's was also raised.

8.3 Recommendations

Based on the findings it is recommended that the priorities be amended as follows:

1. An additional priority is included for HSCT's to develop an implementation plan for the delivery of brief interventions across all programmes of care.

It is further proposed that:

- The importance of ensuring that professionals have the capacity to undertake screening and brief advice will be acknowledged.
- The need for clear timetable for the delivery of Alcohol Brief Intervention training will be considered

9.0 SUBSTANCE MISUSE LIAISON SERVICES

9.1 Commissioning Framework Priorities

Regional Commissioning Priority

- *The current level of alcohol liaison services should be enhanced to meet the national benchmark guideline of 4 WTE practitioners per 250,000 of the population. Current provision is 10 WTE across the region. An additional 18 posts are required.*

9.2 Responses from the Consultation

There was overwhelming support for this initiative with many acknowledging the need for this expansion in service provision. The following points were made;

- The concept of “Substance Misuse Champions” should be explored and developed on Wards to support this service.
- Consideration should be given to extending the role of these posts to Acute General Hospital based Psychiatric Units.
- Effective links need to be established within community settings, care pathways. Specifically the need to strengthen links with low threshold services for those chronic users who are often repeat attendees at ED’s was highlighted.
- Need for consistency in practice, monitoring and assessment was emphasised.
- There was very strong support for widening the role and remit of these posts beyond Alcohol, particularly in the areas of drug misuse and mental health.
- It was felt that these posts should also have a hidden harm brief.

9.3 Recommendations

Based on the findings it is recommended that the priorities remain unchanged.

It is further proposed that

- The importance of Assertive Outreach and partnership working is highlighted in the service aims and role and function.
- The role of “Substance Misuse Champions” and establishing links with Acute General Hospital based Psychiatric Units are explored.
- A commitment to consistency in practice, monitoring and assessment is given.

10.0 Low Threshold Services (LTS)

10.1 Commissioning Framework Priorities

Regional Commissioning Priorities

- *Pharmacy based Needle Syringe Exchange Schemes should be commissioned to meet the needs of local drug using populations.*

- *HSCB/PHA should consider joint commissioning initiatives with NIHE and Supporting People in the further development of low threshold services.*

Local Commissioning Priorities

- *Non Pharmacy based Needle Syringe Exchange Schemes should be commissioned where appropriate.*

- *Low threshold harm reduction services should be available in each HSCT area for those who misuse alcohol and drugs but are unable to access formal treatment services. (Such services may be stand-alone or integrated within broader health services, homeless and or accommodation services).*

10.2 Responses from the Consultation

The important role that these services play was highlighted and the following key points were made;

- Respondents welcomed the commitment to work with Supporting People/NIHE. However, more detail on how joint commissioning will be taken forward was requested. The need to build on the good work already developed between HSC and Supporting People/NIHE was acknowledged.
- Many felt that LTS can play an important role in supporting BBV testing and providing nutrition services.
- There is a need to consider expanding the provision of non-pharmacy based Needle Syringe Exchange Schemes as it was felt by some that these services can offer a more comprehensive and holistic harm reduction service than Pharmacy based schemes. It was felt by some that the role that Pharmacy Needle Exchanges play is over stated in the framework.

- There needs to be improved joint working between LTS and Treatment services along with the development of care pathways.
- The needs of Steroid Injecting Users were highlighted.
- It was also felt that the needs of IV drug users were not prioritised in the framework.
- Some people felt there was merit in considering the provision of dedicated housing support services for women.

10.3 Recommendations

Based on the findings it is recommended that the priorities remain unchanged.

It is further proposed that:

- The need to provide services to steroid users and the importance of assertive outreach and partnership working will be included in the service aims and role and function.
- The need to ensure that IV drug users are supported and offered appropriate services will also be a key function of outreach services.

11.0 COMMUNITY BASED TREATMENT AND SUPPORT

11.1 Commissioning Framework Priorities

Regional Commissioning Priorities

- *Specialist services assisting GPs in managing patient withdrawal from prescribed drugs should be available in each HSCT area.*

- *Ensure Community Addiction Services are adequately resourced to meet the NICE target of 1 in 6 receiving treatment per year. This equates to a 60% increase in the number of alcohol misusing individuals in treatment using the figure of 4402 (alcohol only or alcohol and drugs from the treatment services census) as the baseline.*

- *A shared care substitute prescribing service should be available across all Trust areas, and patients should be managed as part of a shared care arrangement once their opioid substitute treatment has been sufficiently stabilised by Trust services. Patients should be managed in line with Northern Ireland Primary and Secondary Care Opioid Substitute Treatment Guidelines (Draft 2012).*

- *Interventions targeting people within the criminal justice system should be available in Northern Ireland.*

- *Contingency management (CM) schemes should be piloted in Northern Ireland.*

Local Commissioning Priorities

- *Adult voluntary/community treatment service(s) should be in place within each HSCT area working with statutory Community Addiction services within a stepped care approach.*

- *All those who are at risk of blood borne viruses attending Community Addiction Teams, or in other settings such as prisons, should be offered annual testing for HBV, HCV and HIV. Blood spot testing should be available for those in whom venous access is difficult or where further referral would be otherwise necessary.*

- *All opioid dependent clients attending Community Addiction Teams and in prison should be offered Naloxone to reduce the risk of overdose.*

11.2 Responses from the Consultation

There was broad support for the priorities and service description listed in this section. The key points are outlined below;

- The need to provide services to people with Learning disability should be included in the service aims and functions. Lead link staff within learning disability for those who have SM problems should be in place. The need to address Korsokoff's and Alcohol related Brain Injury was also highlighted.

- Recovery Support is not currently resourced sufficiently and requires more prominence within the framework.
- There was overwhelming support for the development of local care pathways. However, the pathways chart included in the document needs to reflect the step down direction of travel as well. The role of Assertive Outreach working within a

stepped care approach needs highlighted more. Service user involvement in the Core Care Pathway approach was also viewed as critical.

- NICE guidance (PH 24, Alcohol Use Disorders: preventing harmful drinking) makes the recommendation that 'Commissioners should ensure at least **one in seven** dependent drinkers can get treatment locally.
- In general there was widespread support of the move to treat the majority of people in the community. However, many felt that more resources are required as there is a view that current services are struggling with providing the necessary support and after care. Whilst the need to increase resources at this level was welcomed, a timeframe was needed for meeting the NICE target of number of people with dependency in treatment at any one time. It was also felt that longer term psychotherapeutic interventions are needed to support people in recovery.
- Concern was expressed at the lack of any monitoring data on the performance of statutory addiction services.
- There was support for Contingency Management schemes.
- Specific difficulties were highlighted in relation to meeting the Substitute Prescribing Target in the WHSCT.
- The provision of Naloxone and BBV should be regional priorities.
- The feasibility of providing day units in rural settings was queried.
- It was viewed by some that the Medical Model of Care still prevailed and that the role and function of statutory services outlined was too narrow.
- The role of Community Addiction Teams in addressing Dual Diagnosis needs to be outlined in the framework. A regional position on the location of dual diagnosis posts within HSCT's is needed.
- There is a need for dual diagnosis support in homeless settings.
- The need for people with a substance misuse problem to be assessed appropriately for PTSD was also highlighted. A consistent approach across all treatment settings needs to be developed.
- Systemic Therapy and Systemic Practices Based approaches should be included in the list of effective psychological interventions.
- The central importance of the "therapeutic alliance" between the therapist and service user was emphasized.

- The role and function of the voluntary agencies needs to be more carefully thought out.
- Whilst the priority for criminal justice interventions was welcomed, it was felt by some that the prison setting should have been addressed within the document.

11.3 Recommendations

Based on the findings it is recommended that the priorities be amended as follows:

1. The Naloxone and BBV targets are moved to regional priorities.
2. The target for number of people in treatment at any one time is changed to reflect current NICE guidance.

It is further proposed that:

- The issue of Dual Diagnosis is addressed within the 5 HSCTs.
- The role of assertive outreach is reflected in the service aims and role and function of v/c sector treatment.
- The importance of developing a recovery agenda within treatment settings will be reflected in the service role and function of both sectors.
- The importance of systemic therapy and the therapeutic alliance will also be reflected in the role and function of treatment services.
- Actions to meet the needs of clients presenting with PTSD are incorporated into the role and function of services.
- Links with learning disability and brain injury departments should be developed with HSCT's.
- Local care pathways need to establish links with prisons to ensure that offenders leaving prison can access services.

12.0 INPATIENT AND RESIDENTIAL REHABILITATION

12.1 Commissioning Framework Priorities

- *Inpatient and residential rehabilitation provision should be reconfigured in order to ensure a reduction in regional variation and ensure equity of access based on need.*

- *A total of 500 in-patient/hospital based treatment stabilisation/detoxification episodes are required regionally.*

- *A total of 200-300 residential rehabilitation episodes are required regionally.*

- *Consider the need for the development of a regional coordination role to ensure that inpatient and residential access is managed based on patient need and priority.*

12.2 Responses from the Consultation

- Concern was expressed at with the language used in 8.42.2. & 8.42.3. It was felt that the wording of these two paragraphs polarised the treatment of substance misuse in the community and the treatment of substance misuse in a residential setting, with the latter being relegated to a 'less valuable' intervention.
- Respondents stressed the importance of service user choice in accessing appropriate treatment as outlined in "Improving the Quality and Provision of Tier 4 Interventions NTA best practice guide 2008".
- Tier 3 provisions need to be adequately resourced to ensure the continuity of care post inpatient treatment.
- It is essential that motivational interviewing is embedded in in-patient provision. Engaging patients in the Recovery Community should also be an integral part of any inpatient provision.
- The outcomes identified should include the number of people engaged in further community treatment, the number of people engaged in the recovery community or self-help groups, improved motivation, and improved self-efficacy rather that measuring success at this stage by abstinence 6 month post inpatient treatment.
- Consideration needs to be given to assisting families with transport costs when the reconfiguration of Tier 4 provision materializes in order to ensure that families are involved in the treatment of their relative.

- It would be important to add that the number of episodes of care is a 'best guess' based on current utilisation not need.
- Stepped care approach must not be too rigid and that the service user and recovery outcomes need to be at the heart of commissioning and service delivery.
- The need for Tier 4 provision for under 18's was raised.
- Some people felt there was merit in considering the provision of dedicated rehabilitation services for women.

12.3 Recommendations

It is noted that any reconfiguration of Tier 4 services will be subject to a separate consultation undertaken by HSCB.

It is further proposed that:

- Where appropriate the suggestions outlined above will be incorporated into the specification for the role and function of service provision.

SECTION 4 - CAPACITY

15.0 SERVICE USER & FAMILY INVOLVEMENT

15.1 Commissioning Framework Priorities

Regional Commissioning Priorities

- *Commission a Service User Network to enhance involvement of adult service users in the planning of alcohol and drug services.*
- *All treatment and support services need to deliver a consistent and agreed standard of support for families and as appropriate, opportunities for involvement in their relatives care.*

Local Commissioning Priority

- *Ensure commissioned alcohol and drugs services demonstrate effective user involvement*

- *Treatment and Support Services should ensure that families receive an appropriate level of support.*

15.2 Responses from the Consultation

Many respondents welcomed the specific focus on service users and families although felt that the two issues should be kept separate. Additional points are outlined below

- Treatment services should ensure that families receive the opportunity to engage in systemic family work, family support meetings or family therapy. In addition to this, the needs of families should be addressed in their own right irrespective of whether the user is in treatment.
- Services need to be resourced to provide support for families, otherwise support will be limited and not in keeping with NICE guidelines. This will have significant resource implications.
- Service user model is not appropriate for under 18's. A separate model should be developed.
- There should be a specific commitment from services to employ users by experience.
- Benchmarking system for measuring service user involvement needs to be developed for services.

15.3 Recommendations

Based on the findings it is recommended that the priorities be amended as follows:

Service User Involvement

1. An additional priority on developing a framework for measuring service user development is included.
2. An additional priority for involving the participation of under 18's in service development is included.

Family Involvement

3. An additional local priority on ensuring that families are able to access support in their own right irrespective of whether or not a family relative is accessing treatment is included.

16.0 WORKFORCE

16.1 Commissioning Framework Priorities

Regional Commissioning Priorities

The following workforce programmes should be in place to support the implementation of the commissioning framework;

- *Basic and Foundation modules aimed at those with no or little knowledge and/or skills in addressing substance misuse.*
- *An accredited substance misuse course for those working on a daily basis in the substance misuse field.*
- *Motivation Interviewing Training.*
- *Specific knowledge of substance misuse and access to psychological skill based courses.*
- *3rd level education courses at both under graduate and post graduate level as required by the service area.*
- *Mentoring programmes which support the acquisition of new knowledge and skills should be piloted and evaluated to inform future content of workforce mentoring schemes.*
- *Services should have in place measures to ensure that staff are supported to deliver evidence based interventions through the following means.*
- *Use of relevant evidence-based treatment manuals to guide the structure and duration of the intervention and ensure a consistent approach is delivered.*

- *Regular clinical supervision for staff from individuals competent in both the intervention and supervision.*

- *Routine use of outcome measurement tools and ensuring that the person who misuses alcohol/drugs is involved in reviewing the effectiveness of their treatment plan.*

- *Routine monitoring of treatment engagement and adherence.*

- *Monitoring to ensure that staff hold a current appropriate registration (as required) and / or qualification and have the knowledge and skills appropriate to the level of intervention offered (See Appendix B).*

16.2 Responses from the Consultation

There was broad support for the overall approach taken. However the commitment required from other sectors to ensure that practitioners have the competence, skills and time to support people around substance misuse was queried by many respondents.

Additional points raised included:

- Clarity was also requested on which groups should be trained at Tier 1 and 2 i.e. teachers, social workers, community sector? It was suggested that PHA should prioritize groups of workers over a number of years.
- There were some specific requests for additional training courses in the following area:;
    - Systemic Practice Training (Tiers 3 and 4);
    - Dual Diagnosis;
    - Post-Traumatic Stress Disorder;
    - working with families;
    - supporting service users in service design, implementation and delivery;
    - Recovery Coaching; and
    - Family Therapy
- It was felt that basic CBT training should be available for a wider group of professionals than just counselling staff.

- A competency based framework must inform the delivery of all training programmes.
- Hidden Harm training should be expanded beyond the training identified to support the Adult and Children's Services Joint Protocol: Responding to the needs of children whose parents have mental health and/or substance misuse issues.
- There was widespread support for an agreed standard in relation to Motivational Interviewing.
- The valuable practice of involving service users in the delivery of training courses was acknowledged and should be further developed.
- Support for manuals to guide therapeutic interventions.
- It was felt that supervisory training was needed.
- Respondents stressed the importance of having strategic discussions with Universities/Regional Colleges on the development of appropriate training courses.
- There was strong support for the multi-disciplinary approach underpinning the training.
- The proposal to pilot the provision of mentoring support was welcomed.
- Some respondents felt that a dedicated training service in early interventions (ABI's) was needed to coordinate and target work more effectively.
- Training should be developed to support professionals who work with drug and alcohol users suffering from Post-Traumatic Stress Disorder and co existing mental health problems.

16.3 Recommendations

Based on the findings it is recommended that the priorities remain unchanged.

It is further proposed that:

- The following additional training areas to be considered;
    - Systemic Practice Training (Tiers 3 and 4);

- Dual Diagnosis;
- working with families;
- working with service users;
- Recovery Coaching;
- Family Therapy; and
- Additional Hidden Harm Training.

- A commitment that all workforce courses are mapped against DANOS.
- The prioritisation of training delivery will take account of regional and local priorities.

17.0 SUMMARY AND CONCLUSIONS

Overall the consultation revealed a strong level of support for the proposals made in the Commissioning Framework. However, some changes will be required to reflect the views of stakeholders. The priorities will be redrafted in light of the feedback and cognisance will be taken of those comments which related to the finer detail regarding components of proposed models, and areas for further consideration.

It has become apparent from the consultation that a transition phase will be needed to move from the current service delivery to that outlined in the framework. Specifically, the effective delivery of the youth treatment service will require considerable workforce development to ensure that those working at Tiers 1 and 2 are competent to deliver the alcohol and drug awareness/early intervention. The early intervention work relating to the Hidden Harm priority will require some workforce development and also a review at local level of the range of early intervention options available and the development of those as appropriate.

A number of regional priorities will require significant financial resourcing. DACTS will be required to ensure that existing local services continue to remain in place until such resources are found.

The revised document will be presented to PHA/HSCB Management Boards for approval before going to the DHSSPS.

The PHA will then move forward with the procurement process once the timescale and methodology is agreed.

Owen O'Neill/Cathy Mullan

5th July 2013

APPENDIX 1

Respondents

1. ACET (NI)
2. Addiction NI
3. Ards Borough Council
4. Ark Living centre
5. ASCERT
6. Barnardos
7. BDACT
8. BHSCT
9. Breakthru
10. Carlisle House
11. Carlisle House Service User Group
12. CHILL
13. CRUN
14. Daisy
15. Department of Education
16. Derry Health Cities
17. Drink think
18. Drug Outreach Team, Drug Arrest Referral Team: BHSCT
19. Drugs Accommodation Support project
20. Extern
21. Gerry Mac Donald (Northern Impact of Alcohol Portfolio manager)
22. Independent sector (Eastern Area)
23. Lisburn YMCA
24. Liz Mc Shane (Independent researcher)
25. Lundbeck limited
26. Mental health and Learning disability
27. Multidisciplinary Homeless Support Team
28. National Children's Bureau (NI)
29. NEELB
30. New life Counselling
31. NHSCT

32. NIHE
33. North West Regional College
34. Northern Area VSCN
35. Northlands
36. Omagh District Council
37. Opportunity Youth
38. PBNI
39. Regional service User network
40. Royal College of Psychiatrists in NI
41. SEHSCT
42. SELB
43. Service User
44. SHSCT
45. Simon Community
46. South Belfast Partnership Board
47. TIPSA
48. Trauma, Alcohol and Drugs NI Best Practice Forum
49. WELB
50. Western Independent Sector
51. Western Investing for Health Partnership
52. WHSCT