Contextualized study of current trends of the alcohol and drug environment within the Western Trust area

SB SOLUTIONS

the arc healthy living centre ltd

FIRST HOUSING Aid & Support Services

DEPAUL Homelessness has no place

HSC Public Health Agency

Setting the Scene

Depaul, First Housing and ARC Healthy Living Centre ('the consortium') are contracted by the Public Health Agency (PHA) until June 2020 for the provision of support, care, facilitation and harm reduction services (Low Threshold Services) for people who are misusing Substances in the Western Health and Social Care Trust (WHSCT) area. The contract was awarded following a public procurement in 2014. Similar contracts were awarded for other Health and Social Care Trust areas.

The procurement process represented the roll out of the PHA and Health & Social Care Board (HSCB) Drug and Alcohol Commissioning Framework for Northern Ireland 2013-2016. This Framework set out the commissioning priorities for alcohol and drug services across the region, aligned to the Department for Health's New Strategic Direction on Alcohol and Drugs (NSDAD) 2011–17.

Figure 1: 4-Map of Health and Social Care Trusts [1]

Over the past 6 years, the consortium has been delivering a harm reduction programme to those who are struggling with addiction and misusing substances within the WHSCT Area. The Harm Reduction Service provides health related interventions, advice and support to those who misuse alcohol and drugs but are unable to commit to formal treatment.

[1] Service specification for the provision of support, care, facilitation and harm reduction services for people who are misusing substances (PHA 2014)

The consortium provides services in Derry~Londonderry City, Limavady, Strabane, Omagh and Enniskillen as well as the surrounding rural areas. Based on the 2016/2017 figures, the Harm Reduction Service provided:

- Support to 292 service users
- Support for 59 service users to access benefits
- 125 service users with support to access Primary Care
- 71 families/carers with information about alcohol/substance misuse and referred to agencies for family services
- 43 service users with referrals to specialist accommodation/appropriate housing or hostels
- 28 service users with access to mental health services
- 67 service users with access to structured substance misuse treatment services
- 8 service users with access to physical disability services
- 8 service users with advice and support on seeking/gaining employment

At an event hosted by Depaul in 2017, Depaul CEO Kerry Anthony MBE said;

> ***"This programme has made significant strides in helping those on the outskirts of society and left out of other services to access the support that they badly need. For many people struggling with substance misuse, of drugs and alcohol, there is a significant chance that they are struggling in homelessness or are at risk of homelessness. The Harm Reduction Service fills a gap that sorely needed filling in the area.***
>
> ***The results are in the figures, this partnership between Depaul, First Housing and ARC/ Solace is helping hundreds of people to gain access to services, reduce the harm to their physical and mental health and regain control over their lives and wellbeing. It is vital that this impactful service continues."***

Contextualised Study

As the consortium enter the final year of its contracted service, it commissioned a contextualised study of current trends of the alcohol and drug environment within the WHSCT area. The research was funded by the PHA. The purpose of the research was to examine key trends, infrastructure and pathways in relation to low threshold drug, alcohol and addiction service provision and how these have evolved over the lifespan of the harm reduction contract, and thus, how this could help shape and direct future provision.

The overall aim of the research is *'to utilise findings to help shape the future direction or configuration of service provision in the West'.*

The key research objectives include:

- ✓ Analysis of existing data from the those involved in Low Threshold and other services across the area to identify trends
- ✓ Analysis of data from public sources to explore trends in drug use and administration of naloxone
- ✓ Gather perspectives from service providers on existing support infrastructure and identify barriers and gaps in service user pathways
- ✓ Gather perspectives from stakeholders and service providers in relation to trends, challenges, barriers and gaps in service provision.

The research is timely given Department of Health plans to consult on the new commissioning framework for regional drug and alcohol services. This is also referenced in the PHA 2018-2019 business plan: *"Continue to consolidate the drug and alcohol services tendered and commissioned under the New Strategic Direction on Alcohol and Drugs (NSDAD) 2011–17 and the PHA/HSCB Drug and Alcohol Commissioning framework 2013–16 including revising the framework to inform future service design and procurement".*[2]

Alcohol and Drug Commissioning Framework for Northern Ireland 2013-2016

The framework for 2013-2016 set a number of regional and local priorities in relation to low threshold services, including:

- Low threshold harm reduction services should be available in each HSCT area for those who misuse alcohol and drugs at harmful levels and / or in harmful patterns of use but are not receiving formal treatment services. (Such services may be stand alone or integrated within broader health services, homeless and or accommodation services).
- Non-Pharmacy based Needle Syringe Exchange Schemes should be commissioned where appropriate;

[2] PUBLIC HEALTH AGENCY ANNUAL BUSINESS PLAN 2018/19

Services described as Low Threshold are those which adopt a harm reduction approach. In the context of the work of Depaul and partners, harm reduction describes policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or drugs. The term is used particularly for policies or programmes that aim to reduce the harm without necessarily affecting the underlying drug use; examples includes needle/syringe exchanges to counteract needle-sharing among heroin users, and self-inflating airbags in automobiles to reduce injury in accidents, especially as a result of drinking-driving.

They make minimal demands on service users and do not attempt to control their substance use. These services usually provide a range of physical, social and psychological interventions and supports, both on an ongoing and a sporadic basis, aimed at reducing drug or alcohol related harm. The services will differ depending on the specific needs of each individual. The support can be delivered through outreach and / or drop in models of service delivery. Low threshold services play a key role in supporting people into treatment as part of a stepped care approach and Low Threshold Services also provide a pathway into treatment.[3]

The pathway into treatment is captured in the 4-tiered model of care, developed by the NHS National Treatment Agency (NTA) in 2006[4] to assist with service planning. The model is based upon a progression from advice/counselling services to address relatively mild-to-moderate substance misuse (Tiers 1/2), to interventions for relatively harmful/dependent misuse provided by specialist community addiction teams (Tier 3) and/or admission to a specialist treatment facility (Tier 4) for dependent/complex misuse. The model is presented in figure 1 below:

Figure 2: 4-Tiered Model of Care [5]

	DESCRIPTION
Tier 1	Provision of alcohol/drug related information and advice, screening and *referral to* specialised treatment services
Tier 2	Provision of alcohol/drug related information and advice, triage assessment, referral to more structured treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare
Tier 3	Provision of specialist community-based alcohol/drug assessment and co-ordinated care-planned treatment and specialist liaison
Tier 4	Provision of specialist detoxification/stabilisation treatment within a hospital/in-patient setting and/or provision of rehabilitation care within a specialist residential facility

[3] Service specification for the provision of support, care, facilitation and harm reduction services for people who are misusing substances (PHA 2014)
[4] National Treatment Agency for Substance Misuse. [National Treatment Agency (UK)] (2006) Models of care for the treatment of adult drug misusers. London: National Treatment Agency for Substance Misuse. 52 p. 2006 update

The Low Threshold Harm Reduction service offered by project partners falls within tiers 1 and 2 of the model.

**The following table provides examples of the types of service provided across tiers 3 and 4 in the Western Health and Social Care Trust area (not an exhaustive list of services but an example of service type, within the tiered model) *.*

Service Provider	Description of Service	Tier 3	Tier 4
Northlands Addiction Treatment	Northlands is an addiction treatment centre situated in Derry/Londonderry, offering both residential rehabilitation treatment and non-residential counselling for people with addiction difficulties. A core activity of Northlands has been helping people who are experiencing problems rising from use of drugs or alcohol. Depending on circumstances and nature of the problem we offer a range of responses: • straightforward advice and information • information • assessment • counselling • family support • residential treatment • aftercare		x
Western Health and Social Care Trust Alcohol and Drug Service (ADS)	The Alcohol and Drug Service {ADS} is comprised of a multidisciplinary team of Nurses, Social Workers, a Consultant Psychiatrist, Junior Doctors and Admin support staff, working together to provide a comprehensive range of specialist interventions / treatments, for people with alcohol or drug related problems. It offers Outpatient treatment via Community Addiction Team clinics throughout the Trust area. This support includes (not exhaustive): • Comprehensive Assessment • Advice and Education • Structured Psychosocial - Interventions: [Counselling, Relapse Management/Prevention, Motivational Interviewing, CBT].	x	

Conclusion

This section has outlined the context within which this report has been commissioned. Low Threshold Harm Reduction work has been carried out by Depaul, First Housing and ARC Healthy Living Centre over the past 6 years, funded by the PHA. The contract is due to come to an end in mid-2020 and the PHA will be commissioning new services across the 4 tiered model of care in 2019/2020.

The partners have observed significant changes in trends of drug and alcohol use and the impact of same over the past 6 years and feel that these trends should be accounted for in shaping the future direction of services. Thus, this research seeks to qualify these trends. The next section provides statistical data outlining key trends, followed by the thoughts and views of key stakeholders. Collectively, this research is used to make a number of conclusions and recommendations.

[5] Inpatient Based Addiction Treatment Services (Tier 4) Proposed Reconfiguration of Trust Services, HSCB, 2013

Drug and Alcohol Context and Profile

Baseline

At the time of commissioning the Low Threshold services in 2014, the service specification provided an indication of

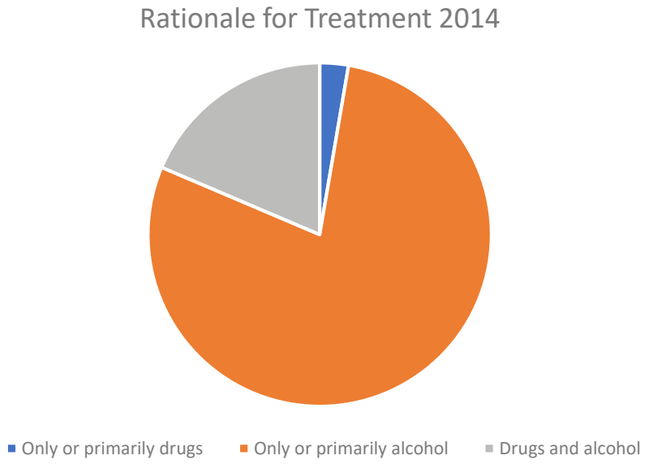
a) the likely profile of service user and;

b) the likely drug and alcohol challenges to be faced by service providers.

The following table was included in the service specification. It offered prospective service providers an indication of the number of people that were in receipt of Low Threshold Services as at 2013.

Numbers currently receiving LTS Services funded by PHA		Drugs and alcohol	Only or primarily drugs	Only or primarily alcohol	Accommodation
Western Area	Drop-in Services	50	6	126	No Service
	Outreach Services	19	4	166	No Service

Across both outreach and drop-in services, 78% of those receiving support was focused on alcohol only compared to 3% drug only and 19% for both alcohol and drug support. The service specification aimed to engage 235 individuals per annum[6].



[6] Service specification for the provision of support, care, facilitation and harm reduction services for people who are misusing substances (PHA 2014)

Census of Drug and Alcohol Treatment Services 2017

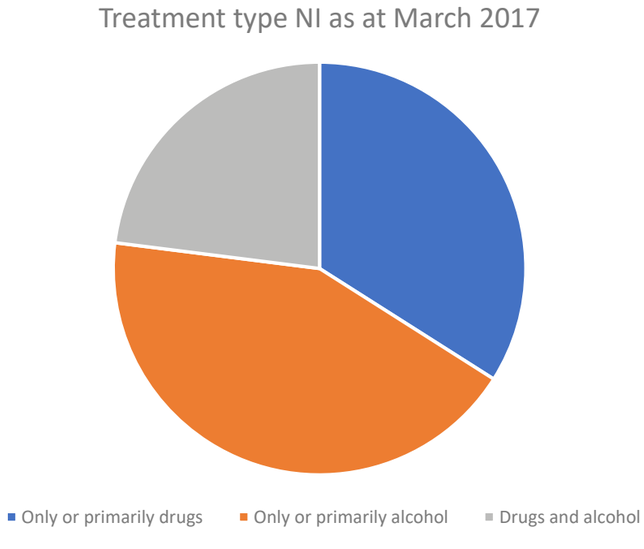
The census of drug and alcohol treatment services by the Information Services Directorate indicates that 5,969 people were reported to be in treatment* for misuse of alcohol and/or drugs as of 1st March 2017[7].

The census of drug and alcohol treatment services reports this figure to be reasonably stable over the past 10 years, except for a spike in 2014 which ***'may be attributed to the introduction of a number of new lottery funded initiatives.*** The census focuses on clients that are receiving treatment and are therefore beyond tier 1 and 2 Low Threshold services.

Nature of Treatment

In relation to treatment type across Northern Ireland, over two fifths (43%) were in treatment for alcohol only, one third (34%) for drugs only and 23% were in treatment for both drugs and alcohol. This represents a shift in pattern over the course of the previous four census reports, the pattern includes:

- a decrease in alcohol only support from 60% in 2007 to 43% in 2017
- an increase in drug only support from 20% in 2007 to 34% in 2017
- increase in those receiving treatment for both drug and alcohol misuse has increased from 18% in 2007 to 23% in 2017.



[7] https://www.health-ni.gov.uk/publications/census-drug-and-alcohol-treatment-services-northern-ireland-2017
**the number of clients in treatment is defined as 'live cases' where individuals are being treated on a one-toone basis. These figures may include a small element of double-counting as individuals may be receiving treatment in more than one organisation. It represents a snapshot figure and cannot be used to derive treatment over the entire year*

Service Type

The census data indicates that he majority of clients (89%) were being treated in a non-residential setting. Those who were being treated for both drugs and alcohol were more likely to have received treatment in a residential setting (17%) than those being treated for drugs only (1%) or alcohol only (6%).

Three-fifths of clients (60%) received treatment through statutory organisations, with 37% receiving treatment though non-statutory organisations, and 3% receiving treatment in prison.

The majority (81%) of those aged under 18 received treatment through non-statutory organisations. For those aged 18 and over, around two-thirds received treatment through statutory organisations and 31% received treatment through non-statutory organisations.

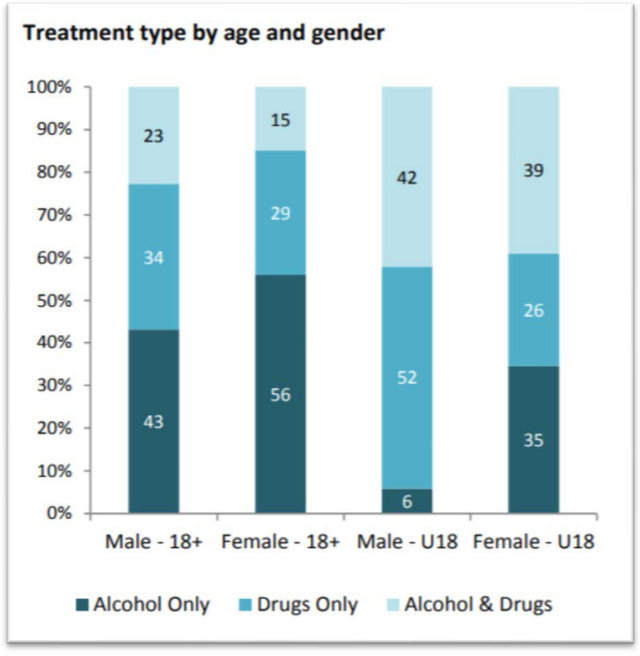
Age Profile

Of those in treatment for alcohol and / or drugs, (60%) were males aged 18 and over, with more than a quarter (28%) being females aged 18 and over.

Three times as many male clients under 18 (9%) were in treatment than female clients under 18 (3%)

With the exception of males under 18, higher proportions of clients were in treatment for alcohol than for drugs.

Under 18s Males were twice as likely as females to be in treatment for drugs only; females were six times more likely to be in treatment for alcohol only.



18+ Males were more likely to be in treatment for drugs only and combined drugs/alcohol; females were more likely to be in treatment for alcohol only.

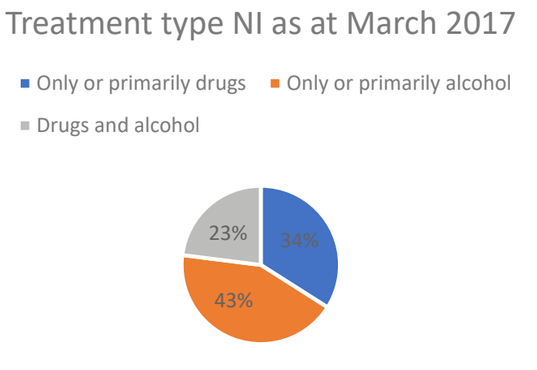
note that the census data provides no further breakdown of age category for clients receiving treatment

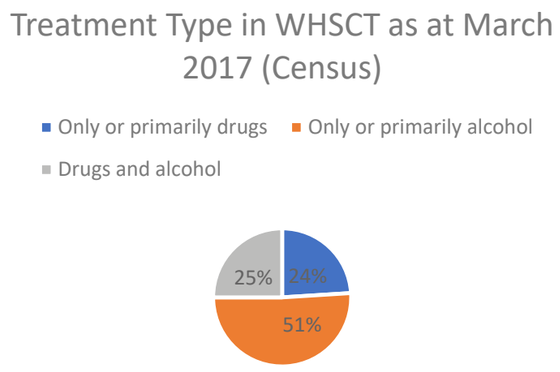
Western Trust Profile

In the Western Trust area as of the 1st March 2017, the total number of clients receiving treatment was reported as 1208, a 51% increase in the number of clients receiving treatment from 2010.

The represents the highest increase in the number of clients receiving treatment of all the Trust areas during that time (BHSCT 17%, SHSCT 34% whilst NHSCT and SEHSCT had a decrease of 24% and 32% respectively).

In the Western Trust area, the following provides a breakdown of the nature of treatment compared with figures overall for NI:





Slightly more than half of those receiving treatment in the WHSCT area (51%) were in treatment for alcohol only compared to 43% across NI, 24% in treatment for drugs only compared to 34% across NI and and 25% for both alcohol and drugs compared to 23% across NI. The majority of clients in treatment in the WHSCT area (87.5%) were 18 and over as of 1st March 2017.

If we compare the 2017 census data to the 2014 service specification from the PHA, we can see a clear trend in relation to decreases in alcohol only support towards drug and multiple substance support. *(it is acknowledged that census data relates to treatment whereas 2014 service specification data relates to low threshold support*

Other Regional Statistics – Alcohol and Drug Related Deaths

The following provide some regional context in relation to alcohol and drug related deaths[8]:

Alcohol related[9]

- ✓ 2017 saw the number of alcohol related deaths in Northern Ireland increase for the fourth consecutive year to the highest on record.
- ✓ 303 of the 16,036 deaths registered in Northern Ireland in 2017 were due to alcohol related causes. This is almost 30% more than was recorded a decade previously (238) and 70% more than 2001 when the time series began. **This definition does not include every death which involved alcohol**
- ✓ The number of alcohol related deaths is higher among males, accounting for 70% of the 2017 total.
- ✓ The largest number of alcohol related deaths continued to occur in those aged between 45 and 54 years.

Drug related[10]

- ✓ The number of males dying from drug-related causes in Northern Ireland has increased by 98% in the last 10 years.
- ✓ 136 of the 16,036 deaths registered in Northern Ireland in 2017 were from drug-related causes. This is 66% more than was recorded a decade ago but lower than the total in 2015, which was also the highest on record. **This definition does not include every death which involved drugs**
- ✓ 74% of the 136 drug-related deaths registered in Northern Ireland in 2017 were males. This is almost twice as many as recorded a decade ago (51).
- ✓ Female, drug-related deaths in 2017 have remained unchanged when compared with the 2007 total.
- ✓ As in previous years, the largest number of drug-related deaths occurred in those aged between 25 and 34 years (37%), with less than 4% occurring in those aged 65 and over.
- ✓ 30% of drug-related deaths had one drug listed on the death certificate, while 46% of deaths listed three or more drugs.
- ✓ 81% of drug-related deaths were classed as drug-misuse deaths, compared to 56% in 2007.

[8] https://www.nisra.gov.uk/statistics/cause-death/alcohol-and-drug-deaths
[9] https://www.nisra.gov.uk/statistics/cause-death/alcohol-deaths
[10] https://www.nisra.gov.uk/statistics/cause-death/drug-related-deaths

Overall, the statistics also indicate that there are notably higher numbers of drug and alcohol-related deaths in areas of deprivation across Northern Ireland. People living in the most deprived areas are four times more likely to die from a drug or alcohol-related death than those in the least deprived areas.

Department for Health - New Strategic Direction for Alcohol and Drugs Phase 2 Final Review – October 2018

The Department of Health commissioned the Institute of Public Health Ireland to undertake research in respect of the review of the NSD for Alcohol and Drugs Phase 2[11]. Part of this review explored the participants views on trends in relation to alcohol and drug consumption. The review has been extended to September 2019. Some of the key findings from the October 2018 report are presented below.

Alcohol Consumption

- ✓ a decline in binge drinking among younger people
- ✓ an increase in harmful drinking patterns in the middle-aged and older population
- ✓ an increase in the frequency and severity of home drinking and “preloading”
- ✓ an increase in the use of high strength alcohol
- ✓ an increase in the prevalence of polydrug misuse including alcohol.
- ✓ an increase in the level of alcohol-related harm in older age groups
- ✓ an increase in the prevalence of “hidden harm”, associated in part with home drinking patterns
- ✓ an increase in the incidence of mental illness and suicidal ideation among those who are drinking excessively or alcohol dependent
- ✓ an increase in the severity of alcohol-related violence
- ✓ increased complexity of service need
- ✓ an ongoing concentration of severe and multiple alcohol-related harms among marginalised social groups.

[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/NSD%20PHASE%202%20Final%20Review%20-%20October%202018_0.pdf

Drug Consumption

- ✓ an increase in prescription drug misuse
- ✓ enhanced accessibility to drugs online and the growth of online supply and social networks;
- ✓ an escalation in risk-taking behaviour in relation to drug misuse
- ✓ the emergence of New Psychoactive Substances
- ✓ an increase in injecting drug use (in Belfast in particular)

Substitute Prescribing

A review of Substitute Prescribing data[12] was carried out as part of the desk review. The aims of prescribing for opioid dependence are to:

- Reduce or prevent withdrawal symptoms.
- Provide an opportunity to stabilise drug intake and lifestyle while breaking with illicit drug use and associated unhealthy risk behaviours.
- Promote a process of change in drug taking and risk behaviour.
- Help to maintain contact and offer an opportunity to work with the patient.

Drug treatment using substitute prescribing helps to protect against a number of harms, including:

- Risk of overdose
- Blood-borne infections
- Risk of offending

On the 31st March 2018 a total of 845 individuals were receiving substitute medication in Northern Ireland. 671 (79%) of those patients were reported as stabilised. 361 (43%) patients were in treatment for 5 or more years. 42% of patients were in receipt of methadone and 39% buprenorphine, the remainder classed as "other" or "unknown" medication.

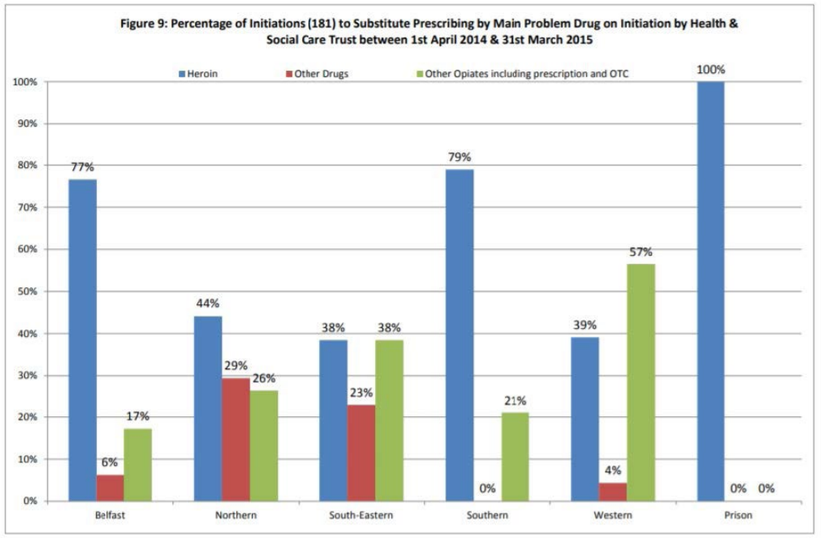
As in previous years, there is considerable variation between Trusts, with 57% of patients receiving methadone in BHSCT area compared to 12% in WHSCT area.[13] There is limited information as to whether this reflects the demand for service, or the distribution of resources.

[12] Northern Ireland Substitute Prescribing Database Report 31st March 2018
[13] Northern Ireland Substitute Prescribing Database Report 31st March 2018

Table 1: Total patients who received Substitute Prescribing Treatment by Trust between 1st April 2017 and 31st March 2018

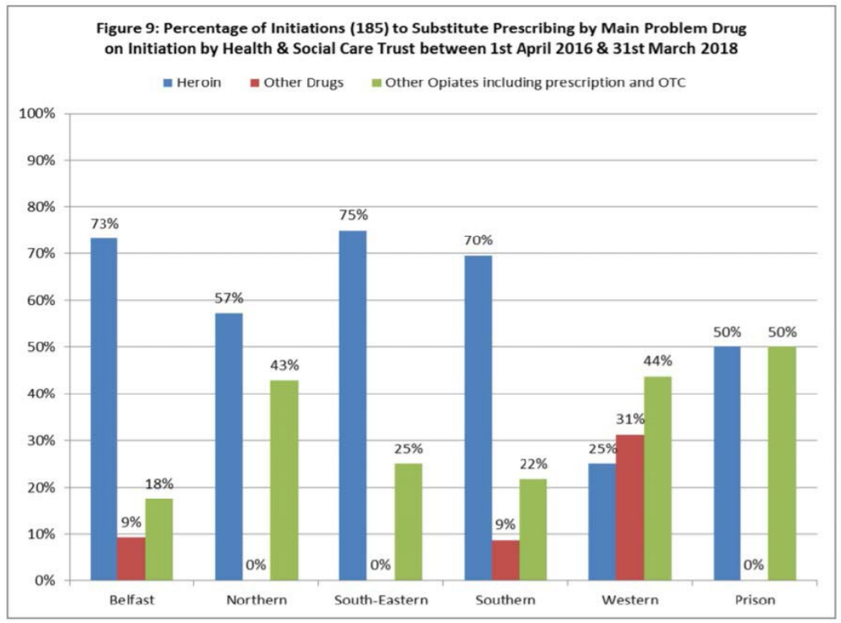
Health & Social Care Trust Area	Total	Percentage	Trust Population	Patients per 100,000 population
Belfast	265	27%	355,593	75
Northern	335	34%	474,773	71
South-Eastern	99	10%	358,708	28
Southern	177	18%	380,312	47
Western	93	9%	301,448	31
Prison	15	2%	n/a	n/a
Total	**984**	**100%**	**1,870,834**	**53**

In respect of the main problem drug use across NI and within the respective trust areas, the following table provides a breakdown of data for 2014 - 2015[14]:



[14] https://www.publichealth.hscni.net/sites/default/files/Northern%20Ireland%20Substitute%20Prescribing%20Database%20Report%2031%20March%202016.pdf

The graph below shows a comparative table for the period 2016-2018[15]:



The images show a decrease in the prevalence of heroin in the Western Trust area (this is matched across all trust areas + prison) with a major shift to 'other drugs' such as cannabis and benzodiazepam. The Western Trust has seen the largest increase in prevalence of other drugs (increase of 27%), higher than any Trust area (next highest is Southern Trust at 9%).

The images highlights that whilst heroin appears less prominent in the Western trust area as compared with others, it has considerably the highest prevalence of 'other drugs' which includes: (in decreasing order of popularity):

- Other drugs: cannabis, other drugs, benzodiazepine,
- Other Opiates - diazepam, codeine, cocaine, tramadol, buprenorphine, and codeine & paracetamol etc16

[15] Northern Ireland Substitute Prescribing Database Report 31st March 2015
[16] Northern Ireland Substitute Prescribing Database Report 31st March 2018

Conclusion

This section has presented a range of statistical data, taken from a variety of sources that show clear shift in drug and alcohol trends from alcohol only, to a prevalence of poly substance use.

The statistical data is matched by participant views in research carried out by the Institute of Public Health Ireland in respect of the review of the NSD for Alcohol and Drugs Phase 2.

In addition, the substitute prescribing data highlights that in the WHSCT area, 'other opiates' (i.e. cocaine, diazepam, codeine etc) are the most common drug. Further, the data shows a significant increase in the prevalence of Cannabis and benzodiazepam use from 3 years ago – a considerably higher increase than in any of the other Trust areas.

This data is now compared to contextualized views of key stakeholders in the following sections.

Consultation Findings

Overview

The research process involved a mixed method approach of 1-1 interview, facilitated group discussion and online questionnaire submission. Data was gathered during the period February – May 2019. The following organisations contributed to the research:

- Depaul
- First Housing
- Arc Healthy Living Centre
- Public Health Agency
- WHSCT Addiction Teams
- WGSCT Mental Health Teams
- Derry City and Strabane District Council
- Civic Alcohol Forum Representative
- SOLACE
- ASCERT
- Addiction NI
- Northern Ireland Housing Executive

The data collection techniques included a mixed method approach of interview, small group focus group and online questionnaire. Following initial data collection, the research team carried out a thematic analysis of findings then where necessary identified further samples of organisations/participants to be interviewed or to take part in the questionnaire. Participant sampling and data collection continued until no new conceptual insights were generated and we had gathered repeated evidence for the thematic analysis, thus reaching theoretical saturation. The consultation findings are thus presented under the following thematic headings:

1. Trends on problem drug use and service user profiles
2. Emerging impact of changing trends
3. Reflections on the effectiveness of existing care pathways
4. Perceptions on service gaps, barriers and challenges

Each of the thematic headings are presented and explored in greater detail in the pages that follow.

Research Limitations and reflections

Efforts have been made to ensure the validity and reliability of findings through multiple method consultation (questionnaire, small focus groups and interviews). As with any survey data, errors due to question non-responses may exist. The number of respondents who choose to respond to a survey question may be different from those who chose not to respond, thus creating bias. The multiple method consultation process was extended on two occasions to enable further engagement and sampling. Thus, the consultation process reached a point of theoretical saturation and the concepts in the thematic analysis are well developed.

Efforts were made to engage the Mental health and Addiction teams within the Western Health and Social Care Trust given their relevance to much of the consultation findings. No response was received, and this potentially represents a gap in findings.

For ease of reference, a small number of direct quotes have been provided in the main body of the report. Further direct quotations from service providers are grouped, per theme, in appendix 1 of the document. The quote selected in the main body of the report best captures the feelings of those responding.

Thematic Heading 1 –
Trends on Problem Drug Use and Service User Profiles

Those responding to the consultation were asked to identify what they perceive to be the main problem drug according to their service user profile. The following represents a ranked list of problem drug use overall:

1. Alcohol
2. Cannabis
3. Benzodiazepines
4. Cocaine
5. Ecstasy/Heroin (these have been ranked equally)
6. Other Opiates/ Novel psychoactive substances

Whist alcohol was identified as the primary problem drug, there appear to be clear trends according to age profile. Service providers identify that those aged 45+ continue to consume high levels of alcohol as the main problem drug for this age group.

Service providers identified the 18-35 age category as being the primary consumers of drugs such as 'benzo's, cannabis, cocaine and ecstasy. However, this category is also heavily associated with polysubstance use.

> ***For over 90% of our service users the drug of choice is alcohol. There is a growing trend of poly substance use. We have seen a rise in female service users in the 35 - 55 age bracket presenting with alcohol addiction issues. For our younger service users, it is polysubstance use. Mainly alcohol and benzodiazepines. Prescription medication is also a continuing issue and growing.'***

Service providers consistently referenced the increased prevalence of cannabis, prescription medications across the Western region as well as the emergence of heroin as a major problem drug, particularly in Derry~Londonderry.

Of *"grave concern"* amongst service providers was the commonness of polysubstance use and the *"willingness of virtually all service users to take any substance available to them".*

> ***The willingness of virtually all service users to take any substance available is a matter of grave concern. Previously there was a divide between alcohol addiction and drug taking. Few service users now use alcohol only"***

Thinking about polysubstance use, 75% of those consulted reported that polysubstance use has increased 'a great deal' or 'a lot' in the past 12 months. Service providers were asked to estimate the proportion of their service users that are using more than one drug. Individual responses range up to 95%.

It is clear that polysubstance use is emerging as a major challenge for service providers across the Western area. The average proportion of service users using more than one drug was 57%, however, some of the service providers offer an alcohol only service and thus reported significantly lower numbers than others. This trend is in line with national trends as indicated in section 2, however the challenge appears more pronounced in the Western area than regionally. The following statement was provided by one service provider, whilst not providing exact figures, provides an example of a perceived change in trend:

> ***2 years ago, our SU breakdown was 80% alcohol issues and 20% substance issues. The main substances used at this time were mainly cannabis, cocaine and opioid substitute prescription medication. Now our SU group is 80% polysubstance use and 20% alcohol. Benzo's, heroin and other opioiods are now prevalent amongst the group".***

The trend to polysubstance use is compounded by an apparent shift in the average age of service user. Those consulted report higher numbers of young people, age 18-24 accessing Low Threshold services. Whilst some services are experiencing high influxes of younger service users than others, the problem drug trends across the various age groups is consistent across the Western area. The consultation findings here have identified a clear delineation between those aged 18-35/40 and those aged 40+. This may have implications for service design.

Of note is that 3 of the 8 service providers who responded to the consultation reported that they are now administering Naloxone as part of their service. The number of Naloxone administrations by service providers has increased from 0 in 2017/2018 to 8 in 2018/2019 and represents a *"concerning trend"* amongst those organisations. The service providers also acknowledged that the administration of Naloxone is now part of the PHA low threshold contract, service providers have developed capacities to provide this service over recent years in response to ongoing demand.

Thematic Heading 2 – Emerging Impact of Changing Trends

The consultation process sought to identify the emerging impact of the changing trends. The following question was asked:

What do you perceive to be the main impacts and challenges of current drug and alcohol trends? (i.e. thinking about rates of overdoses, drug related deaths, A&E admissions, service pressures)

The following responses capture the perspectives of service providers and commissioners in terms of impact on services, the majority of which focus on pressures relating to dealing with complex issues and the subsequent impact on statutory services:

- Admissions to A&E rising and taking up valuable availability. Internet sales allows everyone to be their own anonymous drug dealer.
- The main impact is on services, growing concerns on the impact of client's mental health and physical health and suicide ideation
- A&E admissions are high with service users often discharging themselves contrary to medical advice; this results in frequent re-admissions with no real outcome for service users and puts a strain on services. Poly drug use has resulted in many deaths in our service over the last year in spite of service users having been informed, on a continuous basis, of the real dangers of this practice.

An evaluation report commissioned by Depaul Ireland in 2016-2015 on its 'safe from harm' project offered an economic impact assessment on the effect of its service. Using the Social Return on Investment methodology, the economic impact assessment utilised baseline data gathered by Depaul (2008-2009) in respect of A&E attendances. The target group for the service is the same target group as those accessing the low threshold harm reduction support currently.

In 2008 - 2009, Foyle Haven conducted a baseline survey of 56 service users at that time. The 56 service users were chosen randomly and included men, women, older and younger users. In the baseline survey, 39 of the 56 service users attended A&E during 2008/2009 a total of 456 times. The average attendance at A&E of the 39 that attended was 12 times per service user.[17]

[17] Independent Evaluation of Foyle Haven Safe From Harm Project, January 2016

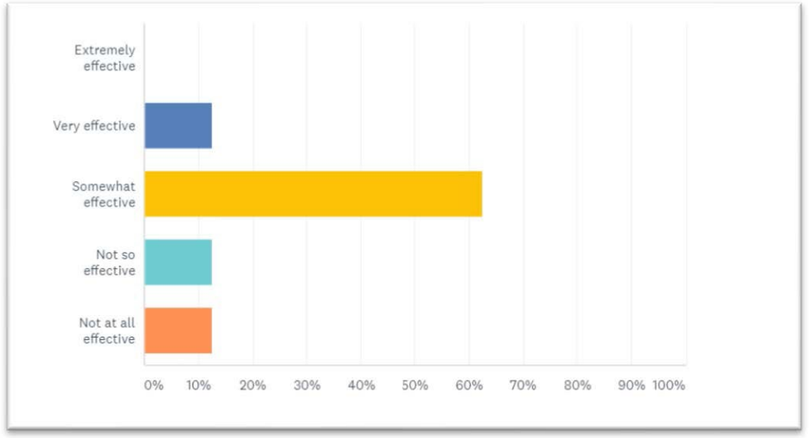
The evaluation report highlights a significant reduction in average attendance, resulting in significant resource savings caused by the Safe from Harm initiative (which no longer exists). However, of relevance for this study was the scale of A&E attendance by service users. Those consulted feel that the shift in trend to poly substance use will exacerbate hospital attendances and add to existing resource pressures within the health service.

Thematic Heading 3 – Reflections on the Effectiveness of existing care pathways

As per the service specification for PHA commissioned services, those contracted are expected to:

- Establish links with other services and ensure that relevant care pathways exist, e.g. for housing, welfare, counselling etc., with clear protocols for referral signed off by the relevant stakeholders.
- Where none currently exist, work with the relevant Trust in the area to establish relevant care pathways with Emergency Departments, Mental Health Services and Physical Disability Services.
- Ensure all staff are aware of relevant care pathways.

Those participating in the consultation were asked to reflect on the effectiveness of the existing care pathways within the Western area. The results are highlighted below.



The majority of service providers (over 60%) identified existing care pathways as 'somewhat effective'. There was a general perception amongst service providers that current pathways are 'too rigid'. As a result, many individuals are not accessing the services they should. There were multiple references to the positive impact of strong personal inter agency relationships which are perceived to lead to a more successful transition through care pathways for individuals. It was also referenced that where pathways are over reliant on strong personal relationships (rather than organisational or structural), there is a risk to their sustainability or longevity.

Amongst the care pathway discussion, a number of subthemes emerged which are worthy of merit and further exploration, these include:

1. Dual Diagnosis

All of the service providers referred to a 'disconnection' between internal statutory services in relation to mental health and addictions. Several references to 'bouncing around services' or 'taking responsibility' were made across the consultation process. This was identified as a major area of concern.

> ***"The referral process can be lengthy and SU can be bounced from different services depending on their perceived need i.e. alcohol, mental health, drugs use. As the majority of our SU's have multiple complex issues then no one particular service will take full responsibility for their care."***

> ***"Sadly, we are consistently confronted by the reality that Mental Health services demand that addiction is first to be addressed. Therefore, service users who continue in their addiction form an increasing number of people with unaddressed and non-diagnosed mental health issues in the sector."***

2. Waiting times and a 'window of opportunity'

Low Threshold Service providers consistently identified a 'window of opportunity' when a service user is in the frame of mind to make a change, and that those in a support role need to be in a position to capitalise on that window of opportunity or risk 'losing' the individual and setting them back months, years or even longer.

Multiple respondents referenced that in some cases whilst existing pathways are clear and reasonably well defined, long waiting lists and a feeling that some 'tiers' will not accept referrals from anyone other than primary care makes the process inefficient and thus missing out on the 'window of opportunity'. This is of particular concern in rural parts of the Western area where a GP appointment may require a 40 mile round trip.

> ***Referral pathways to drug and alcohol / mental health services are slow. Referrals can take up to 2 - 3 months for a comprehensive assessment to take place and during this time, people who may have been very motivated initially, become fed up with the wait."***

> ***In reference to Drug misuse, no support in Enniskillen when you present a person to A & E who is seeking help for their misuse. Referred to counselling and maybe a bed will open up in Northlands in Northwest - 60 miles away. How long do you wait for that?"***

Those consulted reported that the rigidity in care pathways has resulted in challenges in service users moving up and down the 4-tier care model. For community and voluntary organisations, this manifests in increased incidence of dealing with individuals with extremely complex needs and thus increased risk for staff. The rural nature of certain areas of the Western Trust, particularly in Fermanagh and Omagh, compound many of these issues where access is already restricted.

Whilst the consultation identifies significant challenges in relation to care pathways and access to services, the spirit of all consultation discussions was an acknowledgement that services generally are stretched, and that further investment would be required in order to meet the challenges. Thus, a focus on maximising existing relationships, services and pathways would be advantageous in enabling better outcomes for service users. Those engaged also recognised that whilst some of the pathway challenges relate to statutory Tier 3 and 4 services, there is collective responsibility across all of those providing services to ensure that pathways are seamless and efficient as possible.

Thematic Heading 4 –
Perceptions on service gaps, barriers and challenge

A key aspect of the research was to reflect on the key service gaps, barriers and challenges ahead of the consultation process for the new commissioning framework. The following were identified as a priority in the Western area:

Rural Focused Issues

In rural areas, a lack of transport and centralisation of services is perceived to be an issue. Service providers identify that a lack of adequate rural proofed funding for projects to deliver floating support services restricts access for service users. In addition, travel expenses for rural projects are much higher than in urban settings and this is not always understood by funders.

Complex Needs/Dual Diagnosis

A Dual diagnosis service is required to support service users with complex needs who have multiple issues. Frontline services should be provided with access to health services on site such as prescribing nurse or mental health assessments.

Residential/Crisis Response Service

Available beds at short notice is a major gap, these need to be there when a young person is trying to change.

Access to and proper utilisation of residential services at short notice appears to be a challenge in the Western area

Pathways and Partnerships

Reduce waiting times, increased partnership work or more efficient partnership work between statutory and community/voluntary services as well as internally between statutory services is required. Services users, not organisations must be at the heart of the process

Increase in partnership working between all statutory services and the community voluntary sector to share information and training to ensure service users are centred in the approach. Provision of onsite services to frontline services i.e. BBV screening. Free and regular training for voluntary and community services in relation to addiction issues and substance use

WET Hostel

The consultation process includes several references to significant demand for additional WET hostel for men and women in Derry.

Outreach/Floating Support

There appears to be consensus on the need for more harm reduction floating support workers on the ground to assist service users through the periods that they are waiting on Statutory service appointments and post statutory interventions. This can be seen as a ‘stop gap’ initiative as people are moving in between a step up or step down in the stepped care model.

Conclusion and Recommendations

Conclusion

This report sets out a contextualised study of current trends of the drug and alcohol environment in the Western Area. The report findings are an amalgam of statistical data and an exploration of the views and perceptions of service providers, commissioners and other stakeholders across the area.

The research is timely as it precedes the consultation process on the Department of Health's new commissioning framework for Drug and Alcohol services in late 2019. Key concluding thoughts and findings from the research include:

- The Western area has experienced a significant increase in the number of clients receiving treatment in the past 10 years. Drug and alcohol Census data 2017 records a 51% increase in the number of clients receiving treatment from 2010 – the highest increase of all the Trust areas during that time.
- The profile and pattern of drug use also appears to have changed considerably in the Western Trust area. When the PHA commissioned Low Threshold services (2014), alcohol was clearly the dominant problem drug use as reflected in the service specification at the time. Whilst alcohol has remained the main problem drug, the majority of service users are now presenting with polysubstance use, creating complex and high risk challenges for service providers. This trend is consistent across the region but the analysis of data suggests that it is more pronounced in the Western area.
- The substitute prescribing data 2018 highlights that in the WHSCT area, 'other opiates' (i.e. cocaine, diazepam, codeine etc) are the most common drug (after alcohol). Further, the data shows a significant increase in the prevalence of Cannabis and benzodiazepam use from 3 years ago – a considerably higher increase than in any of the other Trust areas.
- The demographic profile of substance user appears to be changing. The majority of service providers report a trend in younger service users reporting for support, particularly aged 18-35 year olds (taken from service user profile data). There appears to be a clear delineation in behaviour with the 18-35 age group presenting with polysubstance use and the 40+ age group are primarily presenting with alcohol misuse issues, albeit with a growing prevalence of prescription medication abuse.
- The changing trends appears to be resulting in increased service pressure across the community and statutory service providers as well as perceived increases in attendance at A&E, suicidal ideation and in some cases, increased number of deaths One service provider report 10 service user deaths in the past 12 months, at an average age of 30. There is a feeling amongst those consulted that this trend will accelerate in coming years owing to: welfare reform and the impact of universal credit, BREXIT and the change in trend from alcohol to poly substance use.
- In addition, the changing demographic to a younger service user appears to be resulting in a displacement of older service user and thus a perceived increase in home drinking and hidden harm – the impact of which is anticipated to emerge in the next number of years.
- Whilst providers acknowledge financial and service pressures, there are examples of how pathways and partnerships are not effective as they could be, particularly in relation to waiting lists, dual diagnosis approaches and requirements for primary care referrals.
- There appear to be significant service gaps across the Western area including better utilisation of services such as accomodation, dual diagnosis services, enhanced floating support and outreach services as well as additional consideration for rural services which are already restricted and stretched.

Recommendations

In considering the key summary findings, the following recommendations are suggested:

1.

The consortium members, statutory agencies and relevant stakeholders should consider the findings of this report and develop a shared position on the needs, challenges and barriers to service provision and pathways in the Western area. Those involved should work to develop a unified and consistent approach to the consultation process on the new commissioning framework, ensuring that the views 'of the West' are adequately reflected and have due influence in the design of services over the next commissioning period.

Recommendation – development of a shared and consistent consultation response alongside this report and submission of same to the Department of Health consultation review as well as senior department representatives.

2.

Having identified a position in terms of future direction of services for the Western area, the partners should engage service users to gather their perspective on proposed change. There will be a requirement to manage expectation and highlight that the proposed change is not guaranteed within the new commissioning framework, but the involvement service users will strengthen and add value to the western 'lobby'.

Recommendation – consortium members and service providers across the WHSCT to share findings of the report with service users and develop a service user addendum to the report, to be submitted to the Department of Health as part of its consultation review

3.

Those consulted recognise the role and value of existing services. There is also wide recognition and acceptance that resources are heavily constrained. Any potential shift in delivery model and service should thus seek to build on and augment existing services and focus on making existing pathways more coherent and seamless. Examples include an enhancement of health related screening, naloxone training for service users and primary care staff. In addition, where existing infrastructure exists, these can be used to enhance accessibility to challenging target groups.

Despite advocating this approach, it is also recognised that the gap between a) the investment in services in the Western Trust area and b) the extent of the issues highlighted in this report, accentuated by welfare reform and universal credit, BREXIT and the change in trend from alcohol to poly substance use: is likely to widen

Recommendation – there is a case for increased investment in services in the Western Health and Social Care Trust area. Consortium members should lobby for an enhanced budget allocation in light of the findings of this report.

APPENDIX 1

Service provider quotations by theme

Thematic Heading 1 – Trends on Problem Drug Use and Service User Profiles

'Alcohol would be the primary substance used by our service users. Most service users use more than one substance. Alcohol use only is prevalent among people over 55 approx. Younger service users, (18 + in our service) use a mixture of aforementioned substances.'

'Younger age group 18 - 35 years are high polysubstance users (opioids, benzos) and alcohol is the secondary issue. Over 40's tend to be alcohol only or as a primary issue with substance use secondary.'

"The prevalence of presentation is getting greater and greater. We are seeing more poly substance misuse and a growing addiction to opioids and prescription medication, but alcohol still remains the main drug of choice for our service users".

"Alcohol would not be classed as a drug and many would not consider smoking Cannabis to be as harmful as other drugs".

'Cannabis use is very prevalent with alcohol but drugs like Xanax are emerging as a serious threat and problem.'

"Approx. 70% people aged between 18 and 55 use more than one substance; the rest, generally older people use alcohol only".

'Average age of SU in past 2 years has lowered, majority of SU fall within the 18-35 age range. Easier access to prescription medication has made polysubstance use the drug of choice as it's cheaper than alcohol and drugs such as pregabalin (Lyrica) can provide the same effects as alcohol.

Thematic Heading 2 – Emerging Impact of Changing Trends

Young people are not concerned with what exactly is in any drug, don't know the makeup but take it anyway

Overdoses, deaths, service pressure.

Current drug trends will ultimately push services to breaking point. Mental health issues and suicides will increase and sadly the incidences of overdose and deaths will probably increase too.

In our services in the past 12 months we have had 10 SU who died where drugs were a contributing factor in their death. The average age of these SU at time of death is 30. Increased polysubstance use has made it difficult to identify what a SU may be taking at times and how to work to reduce the harm and risk to SU. We have had numerous SU admission to A&E/ hospital due to drug/alcohol related illness and injuries particularly in relation to seizures however SU more often than not discharge themselves before receiving appropriate treatment. Staff in service are then tasked with ensuring appropriate follow up with GP and attendance of SU at appointments. Larger attendance figures over the past 2 years have been managed with a smaller staff team than before due to reduced funding and forced redundancies.

It seems that statutory services are extremely overstretched leading to large waiting lists. This has a knock on effect for community/voluntary organisations who are dealing with more complex issues with increased risk. The issues of dual diagnosis have also become more prevalent. Over the last number of years, we have also experienced a number of alcohol-related deaths.

Thematic Heading 3 –
Reflections on the Effectiveness of existing care pathways

"Our service users often present with addictions and serious mental health issues. In this case, the addiction is addressed but the mental health condition is put on hold until the addiction is stabilised which can take months or even years. It would be ideal if both the addiction and mental health condition could be treated separately. Most service user's express frustration that this is not the case and the distress often fuel the addiction".

"We must find creative ways to address the black and white positions taken between Mental Health Assessment/Diagnosis and Addictions"

"The referral waiting time for addiction / mental health services can be many months; people need quick assessments".

"Long waiting list, clients are not being seen, when they need help".

"Services geographically too far spread out. Too slow to intervene when a young person is ready to try to stop using."

"Referral to the Asha centre in Omagh which is a specialist rehab centre requires referral by GP to the drug and alcohol services and onward referral by drug and alcohol services to Asha. This is a lengthy process during which patients have to show motivation to change; motivation is often lost during this lengthy wait"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