

**THE REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY
(NORTHERN IRELAND)**

**ALCOHOL
AND
SUBSTANCE
MISUSE**

EXECUTIVE SUMMARY

December 2005

Vision, Principles and Challenges

1. The Review of Mental Health and Learning Disability has a shared vision throughout. In the case of alcohol and substance misuse this is:
 - Valuing people with alcohol and substance misuse needs, including the rights to full citizenship, equality of opportunity and self-determination;
 - Addressing the challenges facing people with needs in areas of alcohol and substance misuse; and
 - A process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with alcohol and substance misuse problems, to their carers and families.

2. The principles for the Alcohol and Substance Misuse report are also shared throughout the review process. These are:
 - Partnership with users and carers in the development, evaluation and monitoring of services;
 - Partnership with users in the individual assessment process and all therapeutic interventions of care and support;
 - Delivery of high quality, effective therapeutic interventions, care and support;
 - Equity of access and provision of services, including the needs of people from minority cultures, people with disabilities, people subject to the criminal justice system;
 - Provision of services which are readily accessible;
 - Delivery of continuity of care and support for as long as is needed;
 - Provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;
 - Taking account of the needs and views of carers, where appropriate, in relation to assessment, therapeutic interventions, care and support;
 - Provision of comprehensive and equitable advocacy, where required or requested;
 - Promotion of independence, self-esteem, social interaction and social inclusion through choice of services, facilitation of self management, opportunities for employment and social activities;
 - Promotion of safety for service users, carers, providers and members of the public;
 - Provision to staff of the necessary education, training and support; and
 - Services subject to quality control, informed by the evidence.

3. Challenges for this Review of Alcohol and Substance Misuse include:

- Acknowledging that families can make a strong positive therapeutic input they also have needs which must be recognised and met by services.
- Northern Ireland has polarized attitudes to alcohol use with one of the highest levels of voluntary abstinence from alcohol in Western Europe, coupled with high levels of binge drinking and problem drinking.
- There is relative under investment in treatment opportunities for alcohol problems.
- “The troubles” in Northern Ireland have had an effect on the development of the drug culture and the responses of communities.
- There is a need to address harm reduction as a discreet issue in injecting drug misuse within Northern Ireland. This is the first time this issue has been addressed in a Review of this sort.
- The historical and cultural move from an exclusively inpatient treatment model to a comprehensive treatment model with a range of treatment settings has posed challenges to providers. There must be acknowledgement of the cost effectiveness of brief interventions delivered within the primary care system. Considerable gains can be achieved through early intervention which often prevents later development of dependence on alcohol or drugs. These interventions do not work in all cases, and more costly, intensive interventions should be maintained for people who fail to respond to the brief interventions.
- The recommendations for the organisation of services for those with alcohol and substance misuse borrow heavily from the recommendations of the National Service Framework for Alcohol and Drugs. The 4 Tier Model of Service Delivery recommended by the Substance Misuse Advisory Service and the Models of Care developed by the National Treatment Agency should be adopted. There should be a system of co-ordination of care for those with alcohol and substance misuse who have complex needs. Commissioners of services have responsibility for ensuring that mechanisms for such co-ordination are in place.
- The Review process highlighted deficits in current health, education and treatment provision among vulnerable subgroups of the population. Services for children and young people and services for adults with learning disability are highlighted in this respect.
- The Review process focussed upon different groups of people with varying needs in separate chapters. A modern treatment strategy must reintegrate these groups in such a way that a comprehensive seamless service is delivered to meet the needs of the population.

Recommendations

1. Partnership and collaborative working should be encouraged across all sectors. Joint working and co-ordination should be encouraged among all service providers.
2. Referral pathways and protocols should be agreed across services, agencies and community / voluntary interfaces.
3. Commissioners should involve services users, carers and providers in the joint planning and commissioning of services.
4. There should be agreed service specifications, standards, staff competencies and monitoring arrangements.
5. Standardised assessment instruments should be agreed across Northern Ireland and implemented with an IT strategy.
6. Evidence based practice should be promoted.
7. Training and support must be provided for specialist and non-specialist staff. Training programmes should be multi-agency and multi-disciplinary.
8. Service planning should be based on needs assessment with resources allocated to meet identified needs.

Information:

4. The Drug and Alcohol Information Research Unit has usefully co-ordinated information gathering so that we have good data held at population level as well as information about people presenting for treatment. Much of this data is collected in an anonymised way. Continuous household surveys have enabled a picture of drug and alcohol use to be built up over time. This has been supplemented with findings from empirical research carried out in Northern Ireland.

Recommendations

9. A unified approach should be adopted to outcome measures in people with substance misuse problems.
10. There should be a strategic approach to management at key interfaces for the substance misuse services. These include Acute General Hospitals, Adolescent Services, Criminal Justice Service, Services for the Older Age Group, Mental Health Services and Maternity Services.
11. Benchmarking should be enhanced to enable commissioners to address resource issues effectively.

Voluntary and Community Organisations

5. The voluntary and community organisations have made an immense contribution to the prevention and treatment fields within substance misuse. This domain has been subject to cultural effects and rapid evolution over time. Problems encountered by this sector include insecurity of commissioning arrangements, short-term contracts and lack of uniformity in service descriptions and outcome measurements.

Recommendations

12. The range of community based voluntary services in Northern Ireland should be extended. This should be informed by local need, best practice and existing evidence of effectiveness. Consolidation of existing work and securing of long term funding should be a priority.
13. VCOs should be involved in planning of commissioned services.
14. Funding arrangements should be carefully planned in consultation with potential providers.
15. Clear commissioning guidelines should be given to services regarding the type of service required, specifications should be clearly defined. Clear protocols for referral and assessment procedures should be encouraged.

16. Monitoring guidelines for measuring activity and performance, waiting times, referrals, case management and partnership activity should be outlined and be uniform across Northern Ireland. These quality standards should be similar to those in statutory services.
17. Training minimum standards should be agreed by those who deliver commissioned services. Outline of standards should indicate recognised accredited courses only.

Community and Primary Care Settings

6. Most of the treatment delivered to alcohol and drug users is carried out within the Community and Primary Care setting. This is also the setting for which there is the strongest evidence base for various counselling interventions. The evidence pertaining to the use of brief interventions is very strong and can be reviewed at the website address: www.rmhdni.gov.uk . This has helped to inform the recommendation that the brief interventions should be readily accessible to every person in the population of Northern Ireland. Another treatment method which is appropriately delivered at Community and Primary Care level is that of motivational counselling. This forms the basis of much of the opportunistic counselling which can be delivered in various settings across our community.
7. The Review has recommended the adoption of the tiered approach to addiction care as outlined in the Models of Care described by the National Treatment Agency for Substance Misuse (www.nta.nhs.uk). Tiers 1, 2 and 3 of this model are delivered at Community and Primary Care level.

Tier 1 Services:

8. These are non-substance misuse specific services requiring an interface with drug and alcohol services. Specialist staff should support primary care staff in the delivery of interventions. Community Addiction Team staff should be involved. Link workers may be considered in areas with high need, for example to homeless services. These services should be easily available to every person in Northern Ireland.

Tier 2 Services:

9. Tier 2 services comprise open access drug and alcohol treatment services. These are accessible drug and alcohol specialist services, provided by the statutory and non-statutory services. There is a low threshold to access these services and there should be ready access to referrals from a variety of sources including self-referral. The families and carers for people with drug and alcohol problems should also be able to utilise low threshold easy access services for support and counselling.
10. Tier 2 Services must be staffed by competent specialist substance misuse staff. This staff group may have complex training needs and the work should be regarded as highly specialised.
11. Examples of Tier 2 Services include motivational and brief interventions for drug and alcohol users, advice and information services for drug misusers and their families, services to reduce the risks caused by injecting drug misuse, services that minimise the spread of blood borne diseases to drug misusers and outreach services targeting high risk groups.

Tier 3 Services:

12. These are structured community based drug and alcohol treatment services which include psychotherapeutic interventions, motivational interviewing interventions, structured counselling, Methadone maintenance programmes, community detoxification and aftercare following residential treatment for drug and alcohol problems.
13. These services require a higher level of responsibility on the part of the client. They require the user to undertake a full assessment, a care plan agreed by the service provider and client, and a structured programme of care which may involve requirements on behaviour and attendance.
14. A care co-ordinator may be appropriate for complicated cases. In some services a senior member of the community addiction team may be commissioned to carry out this function. In other services commissioners may wish to separately appoint care co-ordinators.
15. There may be variation in the level of provision of Tier 3 services depending on geographical factors. Because of the nature of specialisation and economies of scale, it may not be possible to provide all services in all localities. The issue of access to services is the key and the aspiration is for access to all services for all people living in Northern Ireland who need them.

Recommendations

18. The tiered approach, recommended by Models of Care, should be adopted in the delivery of treatment for drug and alcohol problems.
19. Commissioning structures must be developed, with clear lines of accountability, to ensure comprehensive development of all tiers of delivery in all geographic areas.
20. Service providers should describe their services in keeping with the tier system.
21. All problem drug and alcohol users in Northern Ireland should have access to a range of therapeutic interventions provided by skilled and knowledgeable service personnel.
22. Benchmarks should be developed for all skill levels for Northern Ireland to allow commissioners to allocate staff resources effectively.

Residential Provision

16. Some people with substance use dependence have difficulty achieving abstinence in the community. Inpatient programmes are therefore designed for those drug and alcohol misusers whose needs require supervision in a controlled medical environment. Such services provide a valuable safety net in the management of complex cases within the community.
17. Inpatient drug and alcohol misuse treatment is a tier 4 Service. In order for inpatient services to function appropriately and effectively, tiers 1 to 3 must be properly staffed with trained staff and adequate manpower levels. These units provide medically supervised assessment, stabilisation and withdrawal with 24 hour medical cover and a multi-disciplinary team. Programmes also include a range of additional provisions such as relapse prevention work and aftercare referral services. Various treatment interventions can be facilitated by inpatient treatment. This includes stabilisation on substitution Opioids, withdrawal from substitution Opioids, withdrawal from Opioids, stabilisation on Benzodiazepines for alcohol withdrawal, withdrawal from Benzodiazepines, induction on Opioid relapse prevention with Naltrexone and symptomatic treatment for stimulant withdrawal. Residential facilities can also facilitate psychotherapeutic interventions.

18. The evidence base favours dedicated inpatient units which achieve better outcomes than beds within a General Psychiatric Ward. Research indicates that longer periods in treatment may predict better outcomes; with the best outcomes in those admitted for 28 days or more.
19. Inpatient units are usually staffed by multi-disciplinary teams. In Northern Ireland we aspire to recognise the holistic spectrum of interventions for example carer and family interventions, psychological treatments, and occupational interventions.
20. Some people are accorded priority status based on the following characteristics; severe dependence, co-morbidity, pregnancy or puerperal problems, withdrawal complications, significant personal isolation and unstructured, chaotic lifestyles.

Recommendations

23. Inpatient units should continue to be maintained separately from general psychiatric beds in Northern Ireland.
24. Inpatient beds should be commissioned to meet current and future demands locally. Bed numbers should match Royal College of Psychiatrists recommendations of 3 beds per 100,000 general population.
25. The planned length of opiate detoxification programmes should be at least 4 weeks.
26. Adequate staff levels should be maintained. Nurse staffing levels should be enhanced to meet Telford Recommendations. Staffing should be provided by multi-disciplinary teams.
27. Services should develop clear care pathways including referral pathways and assessment protocols. There should be clear written policies on discharge for reasons of safety, transfer of patients to other hospitals and treatment plans. Aftercare procedures must be in place. Development of these policies should involve service users.
28. The role of Community Addiction Teams in screening potential admissions should be strengthened to ensure “seamlessness” of services. Local conditions may influence this development.
29. Access to inpatient beds should only follow full assessment of the patient. This should be co-ordinated through a care manager.

30. Where Contracts of Care are in place, agreement of the patient must be sought in advance of the arranged admission.
31. The holistic spectrum of interventions should be recognised, with employment of family interventions.

Rehabilitation

21. Residential rehabilitation for dependent drug users provides structured treatment programmes delivered in residential or hospital inpatient environments. Admissions may be short-term (6 - 8 weeks) or long-term (12 - 52 weeks). In some cases clients may move from a rehabilitation programme to a half-way house.

32. An audit of local residential rehabilitation options should be undertaken in Northern Ireland.
33. Information on existing residential rehabilitation treatment options should be collated and made more widely available.

Interface with General Hospitals

22. Alcohol is believed to play a direct or contributory role in 7 to 40% of all acute non A & E hospital admissions. Individuals who are drinking at hazardous or harmful levels may present with a wide variety of medical or surgical disorders, trauma or deliberate self-harm.
23. Various screening tools are available for alcohol related problems, with CAGE and AUDIT (Alcohol Use Disorder Identification Test) the most widely known.
24. The general hospital provides the ideal setting for opportunistic interventions. The provision of specialist staff would enable a range of such interventions including the brief interventions and early interventions. Some dependent drinkers will require more intensive treatments.
25. Delirium Tremens is a potentially life threatening condition which develops during withdrawal from alcohol in some heavily dependent individuals and requires treatment in a general medical hospital. Standardised assessment procedures and treatment protocols may help with recognition and management.

26. Wernicke's Encephalopathy is caused by acute Thiamine deficiency and requires treatment by injection. Protocols are available to guide clinicians in management of this problem.

Recommendations

34. Each general hospital should have a policy on the management of alcohol intoxication and alcohol withdrawal, and associated medical conditions such as Wernicke's encephalopathy.
35. Staff working in the general hospital setting should be offered training and support to opportunistically deliver brief interventions to reduce the harm associated with alcohol misuse.
36. Specialist alcohol liaison services should be developed to provide prompt advice and treatment for individuals in general hospitals with alcohol dependence who are unlikely to respond to brief interventions. Referral pathways to liaison services should be clear.

Harm Reduction Services for Injecting Drug Users

27. Harm Reduction is a widely used term in public health related literature and is assuming high importance within the drug prevention and treatment fields. This is due to the rise in incidence of injecting drug use and the related spread of blood borne viruses. The Department of Health, Social Services and Public Safety has placed emphasis on drug workers adopting harm reducing approaches to care as well as promoting positive health education messages to injecting drug users. The concept of harm reduction in injecting drug use considers containment of drug related harms as a more pragmatic option than efforts to eliminate drug use entirely.
28. The risks involved in injecting drug use include the following:
- Blood borne viruses, hepatitis B, hepatitis C and HIV
 - Direct damage to injection sites and potential bacterial infections
 - General neglect of personal health and overdose
 - Increasing levels of drug dependency
 - Family and relationship breakdown
 - Acquisitional crime leading to criminalisation
 - Homelessness.

29. Substitute Prescribing as a means of harm reduction commenced as policy in Northern Ireland on 1 April 2004. This involves the prescription of substitute opiates, usually Methadone or Subutex to those who are dependent on the opiate drugs. The primary goal is to reduce the incidence of injecting drug misuse by dispensing the substitute drugs in a form which is designed for oral use. In Northern Ireland initial prescription of substitute drugs is by the secondary services, moving to a shared care model where the general practitioners prescribe for stable, established substitute users. Supervised daily consumption in a community pharmacy is the norm for at least the first 6 months of treatment. A key worker is provided by the secondary services. A harm minimisation approach is adopted and excessive alcohol or benzodiazepine ingestion is discouraged. Opportunistic viral testing education and hepatitis B vaccination are employed. Motivational counselling, supportive counselling and relapse prevention are also offered.

Recommendations

37. Educational materials based on harm reduction principles should be developed for appropriate target groups.
38. The experience of outreach programmes in Northern Ireland should be considered with a view to extending such schemes where appropriate.
39. Pharmacy needle exchange should be extended throughout Northern Ireland. There should be an exploration into the efficacy of outreach/community exchange as a key element of preventing the spread of blood borne viruses. These needle exchanges can act as a pathway to other helping services.
40. Training should be provided to ensure skilled and knowledgeable service providers. Training should include: safer injecting techniques, blood borne virus pre and post test counselling, clinical issues in blood borne virus transmission and epidemiology, person centred practice, substitute prescribing and opiate detoxification.
41. There should be an emphasis on person centred holistic care and service user involvement in treatment planning.
42. Treatment protocols and philosophies should be agreed throughout Northern Ireland to ensure equity of treatment for service users.
43. DHSSPS should review the operation of substitute prescribing in Northern Ireland by April 2007.

44. DHSSPS should respond in a timely fashion to resource implications of any escalation in the need for substitute prescribing.
45. GPs and community pharmacists involved in substitute prescribing should be offered appropriate education enabling them to initiate substitute prescribing in primary care.
46. Substitute prescribing programmes should be available in prisons as recommended in the Northern Ireland Guidelines on Substitution Treatment for Opiate Dependence.
47. Law enforcement agencies, community groups and drug users should work together to develop harm reduction policies and programmes that incorporate balanced responses to drug problems in the communities.
48. 'Wet hostels' should be considered providing drug users with high tolerance, low threshold accommodation in targeted areas.

Children and Young People

30. Very limited services currently exist for this target group of young people aged 17 and under. All existing services report under-resourcing. Surveys of 11 to 15 year olds in Northern Ireland have shown increasing levels of both alcohol and illicit drug use over time.
31. Increased levels of drug use appear to occur in certain groups of vulnerable young people. These include young people who have truanted or been excluded from school, have committed crimes, have been homeless, have run away from home and are with a familial drug user. In addition children experiencing trauma associated with the Troubles in Northern Ireland may be regarded as particularly vulnerable.
32. Consultation exercises with young people have reaffirmed the need for:
 - Child and young people specific services
 - Services which provide a range of educational and diversional activities as well as standardised treatments
 - Education for parents
 - Family involvement in treatment and support services
 - Structured services should be available for young people aged 18 to 25 years.

Recommendations

49. A co-ordinated, multi-agency, long-term specific strategy for substance misuse services should be developed for young people under 18 years of age. This strategy should involve, in particular, the education, training, health, criminal justice and child care sectors. This must be underpinned by recurrent funding and supported by appropriate implementation structures. This would build on the existing alcohol and drug strategy and should be integrated within existing children's services planning.
50. The four-tier approach recommended by the Health Advisory Service (1996) should be applied at a local and regional level to include education, assessment, prevention and treatment and should be based on the Models of Care principles. Priority needs to be given to Tiers 1, 2 and 3 with emphasis placed on community based services (see Annexe 8).
51. Services for children/young people, including vulnerable groups, should be underpinned by standardised screening, assessment and treatment protocols and tools. These should reflect the holistic nature of the child's/young person's needs and not focus only on the child's/young person's substance misuse.
52. All services for children and young people must attempt to deal with the needs of young people within their natural environment and background. This should involve work with the family.
53. Those working with under-18s should demonstrate a multidisciplinary, inter-agency approach and staff/personnel must be suitably trained to meet the requirements of their role and responsibilities (see Annexe 8).
54. Standard information gathering processes should be designed and disseminated in order to support the future needs assessment of children's and young people's treatment services.
55. Future research should examine the impact of regular substance use on the vulnerable groups of children and young people as listed in 8.3.
56. Existing provision for children and young people should be sustained and developed. A review to ensure these services are specific to this age group i.e. under 18s is required. Funding should be earmarked for development of services specifically for those under 18.

57. Commissioning bodies should be given the appropriate resources to implement children's/young people's services plans and strategies. Adult services should also be encouraged to address the particular needs of young adults aged 18 - 25 years. These plans/strategies must include the participation of young people through reference groups such as the model currently being piloted by the WHSSB Children's Services Plan.
58. Specific substance misuse services for children and young people should be developed in each health board area based on partnership models across all sectors.

People with Learning Disabilities

33. As more people with learning disability live in accommodation in the community, there are increased levels of alcohol and substance use in this population. People may misuse alcohol or other substances as a means of coping with stress and alcohol or drug use may be perceived by the person with learning disability as a way of socialising or fitting in with their peer group. People with mild learning disability who are more likely to live in community accommodation are more at risk than those with more profound disability.
34. The needs of this population group have traditionally been poorly addressed. Mainstream addiction services frequently exclude such patients on the basis of lack of knowledge of learning disability while learning disability services report lack of knowledge about addictions and appropriate treatment methods. People with learning disability who misuse alcohol or drugs may experience difficulty in accessing appropriate services to meet their needs.
35. The recommendations in this section should be considered alongside the Equal Lives Report; www.rmhldi.gov.uk

Recommendations

59. People with learning disability and substance related issues should be able to access mainstream services. They are likely to require the support of learning disability personnel to utilise the services offered by the mainstream addiction teams.

60. There should be collaboration between both learning disability and mainstream addiction services. This includes the development of a link expert based within learning disability services and also working in mainstream addiction services.
61. Screening tools should be explored to assist staff to detect possible substance-related behaviours, and also mental health problems.
62. An eclectic range of bio-psycho-social interventions should be available. These should be evidence-based, and embedded within the care plan which should be person-centred.
63. A health promotion schools strategy should be developed to target the health and well-being of people with learning disabilities.
64. A regional multi-professional interest group should be developed for planning, delivery, evaluation, promotion of current evidence-based practices and to promote further research for this population within Northern Ireland.
65. Particular efforts should be made to address people with learning disability living independently; with detection, support and education of those most at risk.

Older People

36. In Northern Ireland the percentage of people in the population over the age of 65 is projected to rise from 13% to 24% by 2036. Although the prevalence of alcohol use is lower in this age group than in younger age groups, there is increased interest in the issue of alcohol and older people as this population may experience problems at relatively low levels of alcohol use.
37. Older people may be more susceptible to alcohol problems because of physiological changes which occur with age including loss of lean body mass and loss of water content. It has been suggested that the safe limits for drinking for older people should be lowered to $\frac{1}{3}$ to $\frac{1}{2}$ of those of the general population.
38. When alcohol misuse occurs in older people it can be usefully classified as early onset if the problem drinking has arisen before the age of 55 years and later onset if problematic drinking develops after the age of 55.

39. Estimates for the number of problem drinkers range from 2% to 15% of the older population. Drinking in older people tends to be “hidden”, often due to embarrassment or stigma. Concurrent medication, whether prescribed or over the counter, may give rise to problematic interactions with alcohol use.
40. Close links are necessary between Medical Services, Social Care and Addiction Treatment Services because of the complex nature of biological, psychological and social factors. Families should be involved in treatment where possible.

Recommendations

66. Addiction Services should be sensitive to the identified needs of older people with alcohol problems. Resources should be identified to meet the specific additional needs of the older population.
67. Commissioners should carry out a needs assessment on provision for older people with substance misuse in their catchment area. A regional initiative should be developed to form a perspective on provision of services for older people.
68. Treatment interventions for any service for older substance misusers should be evaluated.
69. Routine screening for alcohol abuse should be included in all initial assessments of older people admitted to hospital.
70. Awareness raising of alcohol related problems in the older age group, should be made available for hospital, primary care, social services and other health care staff. Training in the areas of identification, assessment and intervention strategies should be provided. Staff working in older people’s services in both the statutory and voluntary sectors should be the primary focus for such training provision.
71. Multi-agency co-operation may be valuable in planning, assessment and individual treatment programmes for this client group.

People within the Criminal Justice System

41. Offenders who misuse drugs or alcohol commit more offences than those who do not. There is a strong link between drug misuse and crimes such as shoplifting, burglary, vehicle crime and theft. Heroin, Crack and Cocaine misusers are responsible for 50% of these crimes and around 75% of Crack and Heroin users in Great Britain claim to be committing crime to feed their habits.

42. There is a complex relationship between offending and the prevalence of substance misuse. This section should be considered alongside the report of the Forensic Services Working Committee of the Review of Mental Health and Learning Disability (www.rmhdni.gov.uk).
43. Assessment and treatment of alcohol and drug misusing offenders has been considered in the following settings;

Police Custody:

44. People in police custody are entitled to the same standard of assessment and treatment as any other member of the public. Relevant PSNI staff can encourage individuals to take up treatment opportunities.
45. Arrest Referral Schemes are partnership initiatives setup to encourage drug misusers brought into contact with the police service to voluntarily participate in confidential help designed to address their drug related problems.

Probation:

46. The Probation Board of Northern Ireland (PBNI) includes the following elements in its strategy:
 - Accurate assessment of drug using offenders to inform Courts of the role played by drug use in offending, the needs of the offender and options for sentencing;
 - Establishing co-operative working relationships with statutory, voluntary and community agencies in delivering services to drug using offenders;
 - Joint working within multi-agency teams to deliver assessments and supervision when it is agreed with partner agencies;
 - A continuum of treatment and support between custody and community which applies to adults, young offenders and juveniles;
 - Structured drug awareness and reduction in use programmes as part of supervision and as a condition of an order where appropriate; and
 - Support families affected by drug misuse, especially families of prisoners and juveniles.

Courts:

47. At present Courts do receive reports on offenders from both statutory and voluntary agencies. Drug treatment and testing orders have not been extended to the jurisdiction of Northern Ireland. It is possible that the introduction of drug treatment and testing orders would lead to potential benefits for substance misusers and a more complete range of sentencing powers for the Courts.

Prisons:

48. There are currently 3 establishments within the Northern Ireland Prison Service; HMP Maghaberry, HMP Magilligan and Hydebank Wood.
49. The current provision of substance misuse services in prison establishments is limited. On committal to a prison establishment a primary health care assessment is undertaken.
50. The voluntary agencies have been the most significant providers of addiction services to the Northern Ireland prison population to date. Adult and young peoples services have been developed in partnership with careful monitoring of outcomes.
51. At present the Northern Ireland Prison Service Drug Strategy is under review.

Recommendations

72. People in prison should have access to the same service provision as the general population.
73. Arrest referral schemes should be evaluated and extended if shown to be beneficial in engaging clients previously difficult to engage.
74. Criminal justice integrated care pathways should be adopted (www.nta.nhs.uk).
75. Substance misuse teams, incorporating a harm reduction philosophy, should be appointed within each prison establishment.
76. On the grounds of public health, counselling and testing for HIV, hepatitis B and hepatitis C should be available for everyone.
77. Resources should be allocated for any new service.

Interface with Mental Health Services

52. The rates of co-occurrence of mental health problems and substance misuse problems are high. Approximately $\frac{1}{3}$ of individuals with a mental disorder have experienced a substance misuse disorder, $\frac{1}{3}$ of individuals with an alcohol problem have experienced a mental health disorder and $\frac{1}{2}$ of individuals with an illicit drug problem have experienced a mental health problem.

53. The Strategic Framework for Adult Mental Health Services report should be read in conjunction with this section of the Alcohol and Substance Misuse Working Group Report (www.rmhdni.gov.uk). Common recommendations have been developed across these 2 sections of the Review of Mental Health and Learning Disability.
54. They include a recommendation that people with a dual diagnosis of a severe and enduring mental disorder and substance use disorder are best treated by mainstream adult mental health services providing an integrated treatment service. These services combine high quality psychiatric care with substance misuse treatments such as motivational interviewing, cognitive behaviour therapy and family therapy over an extended period. Such interventions have demonstrated significant improvements in patients functioning when compared to routine care over a spell of 18 months.
55. A personality disorder may co-exist with other mental disorders and substance misuse disorder. Drug and alcohol users with personality disorders benefit from standard treatment for substance misuse disorders at least as much as those without personality disorder.

Recommendations

78. Commissioners should make provision for people with mental health problems and co-existing alcohol or drug misuse. Local prevalence and needs of people with dual diagnosis should be assessed.
79. People with co-existing substance misuse and mental health problems should be treated using an integrated treatment model within a single service:
 - the needs of those with complex, enduring and relapsing mental disorders should be met by adult mental health services;
 - the needs of those with less severe mental health problems, whose main difficulties are directly related to substance misuse, can best be met by substance misuse services;
 - agreed arrangements need to be established between any specialist services for people with personality disorder and substance misuse services;
 - there should be systems of liaison between substance misuse and other mental health services to ensure that people with dual diagnosis have access to the full range of the most appropriate treatment services; and
 - physical health problems associated with substance misuse need to be identified and addressed.

80. The needs of people with co-existing substance misuse and mental health problems in contact with the criminal justice system should be identified and addressed.
81. There should be locally agreed clear care pathways between mental health and substance misuse services for dual diagnosis cases.
82. There may be benefits in having workers within mental health services with additional addiction expertise. They should have special responsibility for patients with a dual diagnosis, and make appropriate links with substance misuse services.
83. Staff working in adult mental health services and addictions services would benefit from joint training initiatives and a sharing of skills relevant to dual diagnosis. While mental health services may require training on the diagnosis and management of substance use disorders, staff working in addiction services require training and regular updates on the recognition of mental disorders, risk assessment, and the management of the less serious mental disorders.

Pregnant Substance Users

56. When substance misuse is present, most expectant mothers will still have normal pregnancies with normal deliveries and minimal inconvenience caused to the family. However there is a need to support this group of women and ensure that all professionals work together to provide support, help and advice which should minimise the risks associated with substance misuse.
57. Particular care should be focused on:
 - preconceptual care;
 - antenatal care;
 - risk assessment during pregnancy;
 - intrapartum care; and
 - postnatal care
58. Care planning should be designed to facilitate the holistic needs of women and the sharing of information from the multi-professional, multi-agency services will be critical. Such an approach to care will work if key workers collaborate and mothers consent to the joint working process.

Recommendations

84. A detailed needs assessment should be undertaken within Northern Ireland to ascertain the extent of drug misuse among expectant mothers.
85. There should be development and support of the interagency services that are available to care for pregnant substance misusers and their families.
86. Specialist training should be provided for all members of the various agencies involved in the delivery of services.
87. Midwifery services should facilitate more accessible and non-judgemental services. Midwifery services and training should develop closer links with the community addiction services. These services should further develop the level of care given to the pregnant substance misuser.
88. Social services are tasked with the safety of the mother and family and it is important that close links are maintained with the addiction services. Family and child care social workers are often the key players in the engagement and treatment of the pregnant misuser. Addiction awareness training is vital for this professional group.
89. Addiction services should develop training protocols to deal with this client group and establish closer liaison with the maternity services, with easier access to addiction services for those in contact with maternity services.
90. Multi-agency training programmes should be developed and supported as a means of developing better understanding within the professional groupings involved. Training needs require investment.
91. There should be development of outreach services for those pregnant women who are unlikely to use formal provision (young people and the homeless).
92. Health education programmes and other preventative programmes need to target the areas of sex education and education on drugs and alcohol for young people.
93. Women who are pregnant should routinely be asked at booking about their use of tobacco, alcohol and drugs. Health advice should be offered.

Families

59. In Northern Ireland we are fortunate to live in a society where family bonds are closer than those in many of our neighbouring countries.
60. The family can be a powerful therapeutic tool in addressing a person's substance misuse. The substance misuse of an individual family member, particularly a parent, can have a detrimental effect on the health of a family.
61. Family members of those who misuse substances have needs which should be identified by health professionals working within primary and secondary care. Services should be available to meet these needs.

Recommendations

94. The commissioning of addiction services should always include provision for carers and families.
95. All health and social care staff should be provided with specific training in substance misuse. The level of training will be relevant to the particular role and setting of work.
96. The recommendations from the Advisory Council on the Misuse of Drugs (ACMD) "Hidden Harm" report (2003) should be considered in a Northern Ireland context.
97. Information regarding dependant children in Northern Ireland should be incorporated within the Northern Ireland Drugs Misuse Database as recommended by the Advisory Council on the Misuse of Drugs (ACMD) "Hidden Harm" report (2003).
98. Evaluation and feedback regarding service provision should be sought from families and children. Families should be listened to, acknowledged and their experiences incorporated at all levels of planning and service provision.
99. Monitoring, evaluation and dissemination of best practice locally should be encouraged. Opportunities should be sought to develop innovative approaches to supporting families.
100. Joint approaches across children's and addiction services via the current children service plans should be extended throughout Northern Ireland.

Smoking

62. Cigarette smoking remains the largest single preventable cause of death and disability in the United Kingdom, causing more than 120,000 deaths each year of people aged 35 or over. In Northern Ireland it is estimated that approximately 3,000 people die each year from smoking related diseases.
63. The prevalence of smoking is much greater in those with mental health problems than the general population. Smoking prevalence in Britain among the general population is estimated at approximately 20%, whereas people with severe mental illness have been shown to smoke at twice the rate of the general population. In fact, it has been estimated that nearly 45% of all smokers in the United States are people with a “mental disorder”.
64. In addition, smokers who have mental health disorders smoke much more heavily than other smokers. In Northern Ireland a smoking prevalence of 92% was found among a small hospital sample and 53% in a community sample of people with mental health problems.
65. Research evidence shows that specific psychiatric diagnosis can be associated with smoking behaviour, with the more clinically severe mental disorders having a greater prevalence and dependency. Long-term “institutional” residents and the homeless population appear to be particularly at risk.

Cessation Interventions:

66. An integrated smoking cessation strategy involving brief opportunistic advice from health professionals, pharmacological treatments and intensive, specialist support has been shown to be effective in promoting smoking cessation in the general population. Such treatments have been endorsed in the Tobacco Action Plan (2002) and recommended for various groups of smokers including disadvantaged adults such as those with mental health problems.

Recommendations

101. In both hospital and community mental health facilities the smoking status of clients should be ascertained at the time of assessment and monitored thereafter by mental health and primary care services.
102. All mental health staff should be trained to offer brief advice to clients at a stage when they are likely to be receptive to its import.

103. A staff training programme should be instituted to address staff attitudes to smoking and their own knowledge about smoking and mental health.
104. Specialist staff should be appointed to plan support services for smoking cessation aimed at those with mental health problems.
105. Staff training would also include counselling skills, group leadership skills and a full knowledge of the evidence base related to smoking and cessation methods. It should also include knowledge of the likely barriers to access smoking cessation services by these clients.
106. Health promotion leaflets and particularly those on smoking, and other cessation materials should be readily available in facilities accessed by people with mental health problems including primary care services.
107. Nicotine Replacement Therapy (NRT) or other pharmacotherapies should be prescribed as required as part of a cessation programme with specialist support. This is important as there is evidence that some people with mental health disorders continue to smoke in conjunction with taking NRT and so experience distressing effects.

The Wider Environment - Homelessness and Employability

Homelessness

67. Homelessness and substance misuse co-occur frequently. Substance misuse is a significant issue among homeless people both in terms of prevalence of use and dependence. The use of substances is associated with high risk behaviours among the homeless population and the incidence of mental ill health among homeless substance misusers. Most drug and alcohol use preceded homelessness and there was a strong connection between the age of first substance use and the age of first homelessness. A smaller number of people began to use substances after they became homeless and some individuals may develop homelessness without ever having a history of substance misuse.

68. An audit carried out by the Information and Research Working Group in 2003 in Northern Ireland demonstrated that few of the homeless people interviewed had access to substance misuse services. The priority for this group of people appeared to be to secure accommodation as a key to stabilising other life issues rather than address their drug or alcohol problem as a primary issue.
69. Homeless people expressed strong views that the substance misuse and homelessness services should be improved to better meet their needs, and that better information should be provided. Prevention was stressed by those interviewed as an important issue to address.
70. This is a difficult group of people for the drug and alcohol services to engage. The priority for this group in accessing the homelessness services suggests that this population should be targeted specifically for drug and alcohol interventions within the homeless service provision. At present there is little integration between the various statutory organisations providing treatment and the homelessness services.

Recommendations

108. The issue of substance misuse among homeless people should be addressed strategically.
109. Joint protocols between homelessness services and community addiction services should be encouraged. Integrated planning should be undertaken.
110. Staff working in the homelessness sector should receive training in the care, management and support of people with substance misuse problems.
111. Staff working in the addiction services should have training in homelessness issues.
112. Harm reduction techniques should be disseminated within the homelessness services.

Employability

71. Many people in treatment for substance misuse have multiple physical and mental health problems which impact on their capacity for optimal occupational function. Comprehensive functional assessment of these individuals is required so that specific interventions may be provided to achieve full potential in the areas of self-care, leisure and productivity. The

use of purposeful activity as an intervention is valuable in identifying clients personal resources. Participation in leisure and vocational activities has a clear impact on the person's self-esteem and confidence, promoting community integration and social inclusion.

72. It may be that paid employment is an unrealistic goal in the short term for an individual with a substance misuse problem. It should be recognised that there are a variety of successful occupational outcomes which may be valued by the individual. These might include variations of paid employment such as therapeutic work, supported employment or part-time work, volunteering, homecare, education and community involvement.
73. The Department for Employment and Learning (DEL) through its welfare, reform and modernisation programme seeks to address the employability needs of its customers, particularly those who are furthest from the labour market. This includes people who have difficulty in obtaining work due to a history of drug misuse, alcohol misuse, homelessness and having a criminal record. DEL aspires to provide specialist employability support for people who claim working age benefits and who experience significant difficulty in accessing jobs as a result of having a history of drug misuse or alcohol misuse.
74. Specific problems encountered by people who attempt to gain employment when recovering from drug and alcohol misuse include stigma, the benefits system, recruitment procedures, chequered work histories, poor existing qualifications and skills, health issues and treatment restrictions.

Recommendations

113. Substance misuse services should focus on employability for all their clients.
114. There should be central co-ordination of agencies providing employability and rehabilitation services for clients who have been misusing substances.
115. A partnership approach should be encouraged between treatment provider services and agencies which encourage workplace rehabilitation and employment.

Implementation

75. This report should be considered with the various reports published by the Review of Mental Health and Learning Disability. The strategic framework for Adult Mental Health Services is particularly important in this respect. Implementation structures for this report at local provider level should mirror those already advocated within the strategic framework.
76. Implementation should be guided by the principles of the Mental Health and Learning Disability Review (paragraph 2 of this summary).

Workforce Requirements

77. The successful implementation of this report requires investment in manpower planning, education and training, and development of appropriate workforce. This must take place across the statutory services and also across the non-statutory providers of addiction services. The necessary workforce is described in the workforce document at www.rhmldni.gov.uk.
78. Partnerships and collaborative working across the traditional service boundaries will be necessary in order to enable proper use of a modern addiction workforce.

Regional Structures

79. Strong central strategic planning and monitoring of the workforce, changing client needs and appropriate services should take place at regional level.

Commissioning of Services

80. Throughout this report there have been many recommendations about commissioning of services, both statutory and non-statutory. A strong regional lead must be given to the commissioning process. This should be informed by the principles of the Review.
81. There should be clear lines of accountability at local and at regional levels for the delivery of appropriate substance misuse services to those who need them.

