Alcohol and Drug Commissioning Framework for Northern Ireland 2013-16

Consultation Questionnaire.

This questionnaire has been designed to help stakeholders respond to the above framework.

Written responses are welcome either using this questionnaire template or in an alternative format which best suits your comments.

Please respond to the consultation document by post or e-mail to

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YOUR RESPONSE MUST BE RECEIVED BY 2611th April

(*Please the relevant tick boxes*)
I am responding: as an individual ☐

on behalf of an organisation ☒ X

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CONSULTATION QUESTIONS

1. Do you agree with the approach being proposed by the PHA/HSCB in the development of a Drug and Alcohol Commissioning Framework for Northern Ireland as outlined in section 3 of this document?

Yes/~~No~~

Comments: We welcome the five key principles as outlined in 3.3 Themes. However, the first key principle we feel is limited by only stating 'evidence based practice. There has been a substantial shift from striving for 'evidence based treatments' - which are derived from studies that have a highly selective screening process for participants and tend to exclude poly alcohol and drug use as well as co-morbidity patients to ensure 'purity' of sample – to validating and incorporating 'practice-based evidence.' Within the academic fields of psychology, social work, psychotherapy and nursing there is a growing acceptance that this development and inclusion of practice-based evidence will enhance both practice and the research base, and more importantly ensure choice for the service user (Hoffman, N. G. 2006. Evidence Based Practices: Promotion or Performance? Addiction Proffessional). Hoffman states that we must be vigilant that the evidence in 'evidence based' supports real-world outcomes. It also needs to be noted that this debate is currently taking place within NICE, as it undergoes a process of change to include social care. One of the five questions that NICE is contemplating is what is its responsibility in relation to evaluating social care interventions and the proposal to consider and validate practice based evidence (Stratton, P. Context 125 2013: Research Update). The National Treatment Agency states as one of its aims - to promote evidence based practice by identifying and disseminating best practice evidence (Improving Services for Substance Misuse NTA 2009).

We therefore feel that the statement would be enhanced should it read something such as: 'evidence based practice incorporating and validating practiced based evidence'.

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SECTION ONE: CHILDREN, YOUNG PEOPLE AND FAMILIES

Drugs and Alcohol

7.1 Education and Prevention

2. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

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3. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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4. Do you agree with the outcomes listed in this section

Yes/No

Comments:_____
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7.9 Early Intervention and Treatment

Early intervention

5. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

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6. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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7. Do you agree with the outcomes listed in this section?

Yes/No

Comments:_____
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Young people's treatment services including CAMHS

8. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

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9. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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10. Do you agree with the outcomes listed in this section?

Yes/No

Comments:_____
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7.21 Hidden Harm

Early Intervention

11. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

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12. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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13. Do you agree with the outcomes listed in this section?

Yes/No

Comments:_____
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<u>Treatment and Support</u>

14. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

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15. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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16. Do you agree with the outcomes listed in this section?

Yes/No

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SECTION TWO: ADULTS AND THE GENERAL PUBLIC

8.1 Education and Prevention

17. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

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18. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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19. Do you agree with the outcomes listed in this section?

Yes/No

Comments:_____
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8.4 Early Intervention Services

20. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

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21. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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22. Do you agree with the outcomes listed in this section

Yes/No

Comments:_____
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8.11 Substance Misuse Liaison Services

23. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

Comments:_____
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24. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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25. Do you agree with the outcomes listed in this section?

Yes/No

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8.20 Low Threshold Services

26. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

Comments:_____
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27. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:_____
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28. Do you agree with the outcomes listed in this section?

Yes/No

Comments:_____
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8.28 Community Based Treatment and Support

29. Do you agree with the commissioning priorities as laid out in this section?

Yes/No

Comments:_____
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30. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/No

Comments:___We would want clarification as to who will be recognised as providing tier three services?
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31. Do you agree with the outcomes listed in this section?

Yes/No

Comments:_____
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8.41 Inpatient and Residential Rehabilitation Provision

32. Do you agree with the commissioning priorities as laid out in this section?

Yes/~~No~~

Comments: We welcome the recognition of the contribution made from residential rehabilitation from the voluntary sector. We also welcome the proposal to continue to support such provision. In the light of this the draft proposal would be strengthed by developing a positive case for the provision of such a service. It is this point that has created difficulty with the language used in 8.42.2. and 8.42.3. The wording of these two paragraphs would suggest an attempt to polarise the treatment of substance misuse in the community and the treatment of substance misuse in a residential setting, with the latter being relegated to a 'less valuable' intervention. This would appear to be in contrast to the National Treatment Agency Joint Service Review on Improving Services for Substance Misuse 2009, which states that residential treatment services form an integral part of commissioned substance misuse treatment systems, and that 'improving the provision of Tier 4 services is an essential element of the NTA's initiative to enhance the quality, consistency and effectiveness of substance misuse treatment.' They state that inpatient and residential treatment services can provide effective responses to the needs of those with the most severe substance misuse problems. Furthermore the NTA's Review of the Effectiveness of Treatment for Alcohol Problems (2006) state in their conclusion, under the heading of Intensive Treatments in different Settings, that time-limiting residential programmes can result in a more cost-effective intervention (14.4.3).

It is also well documented that service user choice is essential and integral to better outcomes, which is stated in this draft proposal 9.4. This document states that service users should be proactively involved in the identification, assessment and planning of their care. We would assume that this includes Residential Treatment. The NTA Review of the Effectiveness of Treatment for Alcohol Problems (2006), points to evidence that service user choice improves the prospects of a successful outcome citing Kissin, Platz, and Su, (1970); and Booth et al., (1998), Millar, (1989); Brehm and Brehm (1981); Miller and Rollnick, (2002). Bracken et al., (2012) writing in the British Journal of Psychiatry argues with others that psychiatry needs to move beyond the dominance of the current technological paradigm, which would be more in keeping with the evidence about how positive outcomes are achieved through fostering meaningful collaboration with service users. The Future Search Conference 2012 organised by Belfast Strategic Partnership states in their 9 th 'Common Ground

Statement' that service users will have full participation in all decisions regarding substance abuse issues – we will respect self-determination by service users regarding treatment plans and pathways Finally service user choice is one of the key components of motivational interviewing to ensure positive outcomes, which is cited in this document as an evidence based approach (8.45.3). Service users have consistently commented on the importance of residential treatment to their recovery highlighting the critical necessity of a safe and secure environment, away from their place of addiction, to reflect, re-evaluate, challenge and make positive choices for their future. The majority have stated that without residential treatment, recovery would not have taken place. This is evidence by a planned discharge rate of 66% - 75% (variation dependent on trust and referral status) compared to national average of around just over 50%. A Community Addiction worker said that many of her clients told her it had been a lifeline and lifesaver. She added, the intensive treatment consolidates the work we do in the community.

Therefore based on the above we recommend that It would increase the credibility of, and enhance the draft proposal if a more positive stance was taken on the benefit of tier 4 residential treatment services by stating: its value within a menu of services offered; who would benefit from such a service (indicators stated in Improving the Quality and Provision of Tier 4 Interventions NTA best practice guide 2008); and the importance of service user choice in treatment planning.

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Role of Secondary Care Co-ordinator

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In relation to regional priorities we welcome the focus to reduce regional variation and to ensure equity of access based on need. However, it would be helpful to know how the proposed figures for inpatient and for residential treatment were derived. The variation in the figure requiring rehabilitation would appear significantly varied having implications re planning for those who will provide this service.

Secondly, we are not convinced that a regional co-ordinator in a central location would be the best method of managing access to services, and thus the best use of public monies. We would ask questions as what is the envisaged problem in order to arrive at this solution. What would be the envisage function of such a role? If they had a clinical aspect to the role how would they make decisions collaboratively with the service user with whom they have no contact? We do not think it would be helpful to have an assessment aspect to the role as this would be viewed as another barrier to overcome in accessing services, while undermining the professionalism of Tier 3 workers. Our experience has been that working within a collaborative and consensus model with tier 3 workers has ensured an effective process in the referral, assessment and outcomes for service users.

We would want to see the promotion of a consensus model to the decisions made about a service users treatment pathway and the service user being at the centre of their treatment journey. Currently collaboration between service provider, referrer and servie user has demonstrated effective and timely access to services.

Stepped Care Appraoch / Core Care Pathway

With regard to Core Care Pathway it is not clear as to who or what is the single point of entry. We had further questions as to who is the secondary care co-ordinator – or is this the regional co-ordinator as stated above? In employing this version of a stepped care model our concern would be that additional steps are not put in place to make access to services more arduous than necessary. The Future Search Conference 2012 organised by Belfast Strategic Partnership states in the Common Ground statement 8 that; 'We will ensure that people that need support have easy and timely access to services that are appropriate to their needs.'

The National Treatment Agency for Substance Misuse, Review of the Effectiveness of Treatment for Alcohol Problems (2006), state 'service users should be given a substantial degree of choice over which step they enter the system, rather than being assigned to treatment based solely on professional clinical judgement' (2.8). Although they recognise that complete self-selection is not always possible because of financial constraints, they argue that it is desirable within a limited range of appropriate options including inpatient V outpatient treatment choice be given. It is within this context that the National treatment Agency, though in agreement with the basic principle of a stepped care approach, suggest that 'depending on the nature of their problems and the severity of dependence, service users should be able to enter the stepped care model at any level – not necessarily the lowest point.' In summary they go further by stating that the stepped care model is primarily a rational system of resource allocation and is limited when viewed as a treatment model

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It is worth noting that the stepped care model is ostensibly a tool that fits within the medical model. However with the shift in postmodern thinking, from knowledge and expertise residing with the professional to shared knowledge and expertise i.e. residing also with the consumer / service user, it would suggest the model's validity rests in its ability as a means to allocate limited resources. An article published in the British Journal of Psychiatry (2005), Stepped Care in Psychological Therapies: access, effectiveness and efficiency, concludes that the jury is still out as to whether stepped care might be an efficient method of delivering psychological or psychosocial based services. The authors suggest it may be appropriate for disorders in which adverse consequences would not result from starting patients on too low a step, or where failure at lower levels does not greatly affect later outcome. They suggest that there will be cases where early intensive treatment is actually more clinically effective and cost-effective than a minimal intervention, and suggest more severe and chronic disorders would be better managed through complex collaborative models of care. The document Models of Care for Alcohol Misusers (2006), further adds weight to the above. They caution that it is important to recognise that the stepped care model is not rigid, so that those service users

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identified at the outset as being unlikely to respond to a less intensive intervention, including moderately dependent drinkers who have additional problems or who are already known to services and have previously been treated and relapsed, may require the more intensive or prolonged intervention from the outset.

It is also worth noting that, as reported in Addiction Today (July/August 2010), a new modern framework is being developed for consultation by the NTA for substance Misuse which will be a more integrated treatment system which places the service user and their recovery outcomes at the heart of commissioning and treatment delivery.The Department of Health recently produced a paper – 'The Transition to Public Health England, Action Plan for the NTA 2011-2012' – within which they argue for a 'New Framework for Recovery to replace The Model of care for Treatment of Adult Drug Misusers (2006) and The Model of Care for Alcohol Misusers – section on treatment of dependence- (2002 / 2006). The goals of this framework are:

1) To begin creating an integrated system of recovery-orientated treatment that helps people overcome their dependence for good.

2) Increases access to treatment.

3) Reduces harm that addiction causes to our communities.

4) To re-orient the local systems to commission a range of services which provide tailored packages of care that gives individuals an opportunity to choose and construct their recovery support in their journey to life free from dependence.

They argue for the promoting a shift in care-planning practice towards people being able to plot and build their own recovery plan, stating that an individual recovery plan will empower service users and enable them to take greater responsibility for rebuilding their lives.

Therefore it would be paramount to build in the principle of flexibility and collaboration and with service users, promoting self-determination and service user choice, into the Care Pathway Map in order to ensure better outcomes, and to acknowledge the limitations of a stepped care approach such as less appropriate for more severe or chronic disorders.

33. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes~~/No~~

Comments: With reference to 8.44.1 the Intergrated Care Pathway and the stepped care approach please see above.

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With reference to 8.45.3 Interventions and Therapies we welcome the inclusion of behavioural couples therapy, and accept the approaches listed as evidence based on clinical trials. However we would wish to make several comments. The list of formal psychological therapies is as we stated in response to question 1 limiting and restrictive, to both practitioners and service users. It seems incredible given the space that the draft document has allotted to engaging with the family and family work, that systemic psychotherapy and systemic practice models are not listed. Mirza (undated) Institute of Psychiatry Kings College London in a review of a number of controlled trials of family therapy in the treatment of susbstance misuse concluded that treatment involving family members were more effective than those which did not. Copello et al (2006) argues that there is increaslingly robust evidence that supports both family focused and social network focused interventions in substance misuse treatment. Others whose research evidence supports systemic based models of intervention are Liddle & Dakof 1995; Heath and Stanton1991; Sheidow and Henggeler 2007. This research demonstrates substance misuse as embedded in a socio-cultural context that strongly determines its character and manifestations. These are sometimes group under the umbrella of muti-systemic therapy or multidimensional family therapy. Carr (2000) further states that the logical extension of systemic family therapy is multi-systemic ecological treatment approaches and employing these principles to working systemically with individuals. The Journal of Family Therapy (2009) (31) sets out core concepts that have emerged from systemic therapies that have a strong evidence base for working with substance misuse, around which practitioners should base their treatment approaches; working with whole systems; collaborative stance not confrontational; clients can have multiple goals; outcome measures to include psychosocial goals; value of relationships; importance of fit of therapeutic approach to values and cultural beliefs of client. These core concepts can be found in models of substance misuse treatment such as Solution Focused (Carr 2000), Narrative Therapy, Appreciative Enquiry (McAdam, E & Mirza 2009) Systemic Motivational Interviewing (Steinglass 2009) Systemic Couples Therapy (Fals-Stewart et al 2009). The NSW (New South Wales) Practice Guidelines on Drug and Alcohol Psychosocial Interventions (2008) have in their list of recommendations Systemic Approaches including Solution Focused, Narrative and Systemic Couple therapy.

Secondly it was very surprising that no reference was made to, what is now widely accepted across all approaches and psychosocial treatments, the therapeutic alliance. It seems more inexplicable that reference to the therapeutic alliance is not mentioned following the workshop organised by the PHA on Psychological Interventions at which the speakers from NTA made this very point – that a good therapeutic alliance was now accepted within the NTA as essential to better outcomes. Wild and Wolfe (2009) state that following large methodologically strong controlled trials of psychological and pharmacological interventions for alcohol problems (project MATCH, UKATT and COMBINE) that these results all point to the role of general features of addiction treatment and are not tied to particular treatment

approaches or interventions. Stratton (2012) also points out that there is no clear evidence of the superiority of one treatment over another and rather than NICE rejecting all but a few, which has resulted in the destruction of patient choice, it would serve the public better if it were to recommend against those that demonstrably are less effective or more damaging namely confrontational therapy, while making all other therapeutic treatments available to the public.

Orford (2008). also states that the focus needs to be the change processes that are are common to effective therapies and not not on specific therapeutic models.The general features, mentioned above, of addiction treatment are cited in several studies and summarised by Longabays (2007). They cite 3 non-specfic factors of which one is the client / therapist relationship while the other two are the environment and client behaviour outside of treatment. One of the most comprehensive and rigorous reviews of all available data was compiled by the American Psychological Association 2002. Their findings were that the therapeutic relationship makes the most substantial and consistent contribution to outcomes independent of the specific type of treatment, and recommends that practitioners make the creation and cultivation of therapy relationships a primary aim in the treatment of patients. Much has been written about what are factors of this relationship that make it effective which space doesn't permit to discuss here. Suffice to add that Mearns and Cooper (2005) state three that are demonstrably effective: level of empathy of therapist; the quality and strength of the collaborative relationship between client and therapist; the level of agreement on the goals of therapy.

Firstly. We would argue that alongside the list of evidence based approaches Systemic Therapy and Systemic Practices Based appraoches should be cited.

Secondly, reference should be made to promoting an integrative treatment approach to, especially in relation to co-morbidity, incorporating psychosocial strategies for both substance use and mental health problems in to the same intervention.

Thirdly, It is vitally important that the document cites the importance of the Therapeutic Alliance and states that only those approaches which promote and enhance the therapuetic alliance will be recommended.

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34. Do you agree with the outcomes listed in this section?

Yes/No

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SECTION THREE: CAPACITY

9.1 Service User and Family Involvement

36. Do you agree with the commissioning priorities as laid out in this section?

Yes/N~~o~~

Comments: In principle we would agree. However we want to express concern by use of the words 'involvement' and 'having their voice heard.' Evidence is now undisputable that the greater the collaboration between the worker and the client the better the outcome. We would like to see more robust and committed language to not only 'hearing' or 'involving' service users, but to creating processes and systems whereby self-determination as stated in the Common Ground statement of Future Search can become more of a reality.

The commissioning priority in relation to Family Involvement is welcomed but needs to go further in light of the evidence of the efficacy of Systemic and Family Therapy. Thus under Local Commissioning Priorities there needs to be a separate bullet point stating that Treatment and Support services should ensure that families receive the opportunity to engage in Systemic Family Work – Family Support Meetings or Family Therapy.

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37. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/N~~o~~

- Comments: General welcome of role proposed for service users. One of the roles omitted is that a structure is developed whereby Service Users can provide feedback to service providers both statutory and 3rd sector, which can effectively influence what and how the service is delivered.

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  In relation to 9.5.2 under point 4 (after - usually consists of at least five weekly sessions) a further bullet point needs to be added stating – Facilitated by systemically trained staff

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38. Do you agree with the outcomes listed in this section

Yes/No

Comments:_____
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9.7 Workforce Development

The workforce development commissioning priorities are designed to ensure that those working in the field of alcohol and drugs as commissioned by PHS/HSCB are competent and confident to deliver all aspects of this work commensurate with their role and function.

39. Do you agree with the commissioning priorities as laid out in this section?

Yes/~~No~~

Comments:___P 77. While we welcome the commissioning priorities we would want to add Systemic Practice Training. Although we accept that this may be included in the 5th bullet point, we feel it is essential to professionals working in this field that it warrants mentioning in its own right.

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_Under the point 'services should have in place measures to ensure that staff are supported…… ' the commissioning framework document needs to state its obligation placed on commissioners to a commitment to resourcing the activities listed. We welcome these activities and see them as paramount to providing an effective service.

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40. Do you agree with the Service Aims and Role and Functions outlined in this section?

Yes/~~No~~

Comments:____In table page (75), given the evidence we have stated elsewhere in this response it would suggest that under Youth Treatment, Brief Interventions, and Adult treatment that training in Systemic Practice must be included. Target audience would depend on expertise of training required for level of service provided.

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41. Do you agree with the outcomes listed in this section

Yes/No

Comments:_____
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42. Do you agree with the findings of the Equality, Good Relations and Human Rights Template that accompanied this document

Yes/No

Comments:_____
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43. Are there any priorities for commissioning that are not reflected in this framework?

Yes/No

Comments:_____
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FURTHER COMMENTS

44. Please use the space below to inform us of any additional comments you wish to make in relation to the Drug and Alcohol commissioning framework.

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