Area: Low Threshold Services

Evidence of practice
(narrative of previous model based on PMR data, uptake of service etc.)

Services described as low threshold are those which adopt a harm reduction approach, they make minimal demands on service users and do not attempt to control their substance use. Low threshold services are accessible and have minimum criteria to restrict who can access. While low threshold services do not require that the service user undergoes counselling or other healthcare interventions, these may be offered. Low threshold services may also provide a pathway into treatment.
Low threshold services 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. These 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. Some service users will engage with this service on an ongoing basis whilst others will only engage in a crisis situation.

The PHA invited service providers to provide low threshold support, care, facilitation and harm reduction services for people who are misusing substances in each of the Health and Social Care Trust areas across Northern Ireland. The tender was divided into five separate lots mirroring the HSC Trust areas.

The key objectives of the Service were:

- To provide a person-centred service to those who misuse drugs and alcohol at harmful levels (and who are not able or willing to consider abstinence or engage in structured treatment), to reduce the harm caused by their dependence on substances
- To facilitate access to other relevant support services (housing, health, employment, etc.)
- To adapt service provision (eg balance between drop-in versus outreach), service delivery and range of services required from the menu of services in line with the needs of the service user population, as needed in each Lot area
- To ensure that relevant pathways are established for service users
- To ensure appropriate liaison and engagement with the families of service users
- To ensure service users are involved in the design and delivery of the Service in accordance with the PHA Service User Engagement Framework
- Where specific requirements for supported accommodation are identified in a locality, provide dedicated support or facilitate access to existing accommodation
- To advertise and promote the services through relevant media

<u>Uptake of services</u>

Programme targets have been exceeded within all the HSCT areas (no data available for Belfast HSCT) with service pressures identified.

Through the Impact Measurement Tool Report 2017/18, alcohol was identified as the main substance used by service users, followed by heroin and cannabis. Low-type engagement had the highest uptake within the Northern and Southern localities whereas within the South Eastern and Western localities the highest uptake was for high-type engagement.

Although there is regional variation, most service users were supported to access primary care, followed by access to Structured Substance Misuse Treatment (SSMT) services; benefits and referral to specialist accommodation/appropriate housing.

Overall, the majority of service users were referred to the service, with only a small number of self-referrals, except in the Western locality where the majority of referrals were through self-referrals.

The number of families/carers provided with information about alcohol/drug misuse as well as those engaged to support outcomes for clients was low across the localities.

	exceeded		met		not met

	Number of individuals provided with service		No. engaging for first time	No. of in-depth assessments
Locality	**Target**	**Total 2018/19**		
Belfast	n/a	n/a	n/a	n/a
SE	325	360	328	257
North	258	271	155	155
South	141	169	118	104
West		579	166	398

Locality	No. who report Injecting Drugs	No. whose Primary Substance is Alcohol	No. whose Primary Substance is Drugs	No. whose Primary Substance Are Drugs AND Alcohol
Belfast	n/a	n/a	n/a	n/a
SE	23	180	130	50
North	42	103	65	25
South	40	107	68	15
West	25	325	25	215

Overview of main areas from commissioning framework previous evidence review (*insert links to PHA D&A commissioning framework*)

The Alcohol and Drug Commissioning Framework for Northern Ireland 2013-16 (https://www.publichealth.hscni.net/sites/default/files/Drug%20and%20Alcohol%20Commissioning%20Framework%20Consultation%20Document.pdf) sets out the commissioning priorities for alcohol and drug services within Northern Ireland. It states a number of regional and local commissioning priorities in relation to low threshold services. These include:

Regional Commissioning Priorities

- Pharmacy based Needle Syringe Exchange Schemes should be commissioned to meet the needs of local drug using populations;
- HSCB/PHA should consider joint commissioning initiatives with NIHE and Supporting People in the further development of low threshold services.

Local Commissioning Priorities

- Non Pharmacy based Needle Syringe Exchange Schemes should be commissioned where appropriate;
- Low threshold harm reduction services should be available in each HSCT area for those who misuse alcohol and drugs but are unable to access formal treatment services. (Such services may be stand-alone or integrated within broader health services, homeless and or accommodation services).

(Page 17 of the D&A commissioning framework)

Following a review, the evidence and policy recommendations can be summarised as follow:

- Harm reduction interventions such as needle exchange, advice and information on safer injecting, reducing injecting and preventing overdose should be locally

available;

- People with alcohol misuse problems unwilling or unable to consider receiving formal treatment should be able to access advice and information about drugs and alcohol and basic health care;
- Low threshold services play a key role in supporting people into treatment as part of a stepped care approach;
- Homeless people's substance misuse cannot be addressed without also addressing their housing problems.

(Page 50/51 of the D&A commissioning framework)

Overview of new evidence base review *(key recommendations for consideration)*

NICE PH 52 – Needle & syringe programmes (2014) replaces PH18: reviewed in 2019

https://www.nice.org.uk/guidance/ph52/resources/2019-surveillance-of-needle-and-syringe-programmes-nice-guideline-ph52-6653098909/chapter/Surveillance-decision?tab=evidence

- Need for data collection and analysis to establish trends in user profiles (eg demographics, characteristics of other harm, types of drugs, etc) to inform harm reduction advice and support services in timely
- Commission generic and targeted services to meet local need, eg ensure services are offered at a range of times and in a number of different locations
- Services should be accessible and provide advice and information on services that aim to reduce the harm associated with injecting drug use; encourage people to stop using drugs or to switch to a safer approach if one is available (for example, opioid substitution therapy); and address their other health needs. Where possible, offer referrals to those services.
- Develop and implement a local, area-wide policy which includes services for young people who inject drugs, how local services will achieve the right balance between the imperative to provide young people with sterile injecting equipment and the duty to protect (safeguard) them and provide advice on harm reduction and other service
- Commission integrated care pathways for people who inject drugs so that they can move seamlessly between the full range of services, including treatment services

2016 Understanding and preventing drug-related deaths (PHE)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669308/Understanding_and_preventing_drug_related_deaths_report.pdf

- correlation between economic and health inequalities, deprivation and drug-related deaths;
- significant risk of drug-related deaths for people who move between services for drug treatment, mental health, housing support or physical health, and have the most complex needs;
- periods of greatly elevated risk on entering and leaving drug treatment but significant protection during treatment.

General principles for action nationally and in local areas to tackle current high and increasing levels of drug-related death:

- ensure that the complex needs of drug users are met through coordinated, whole-system approaches and aligned commissioning, which address health inequalities and provide better access to physical and mental healthcare, along with social supports such as housing, employments and benefits
- maintain the provision of evidence-based, high-quality drug treatment and other effective interventions for people who use drugs, including those currently not being reached, to continue to save lives

Drug treatment service commissioners and providers, with other local services, supported by leadership and advice [from Public Health England]*

- ensure treatment is easily accessible and attractive, improving access through, eg, outreach, needle and syringe programmes, and accessible opening times
- consider the evidence for and value of broader harm reduction interventions in reducing drug-related deaths, including the provision of naloxone
- share learning and intelligence with homeless services who have contact with those at high risk
- focus on intervening following non-fatal overdoses (a major risk factor in predicting future drug-related death)
- support improved access for people who use drugs to physical and mental health care services
- engage stop smoking services in drug treatment, including the use of e-cigarettes where appropriate
- ensure services recognise the specific and different needs of older and younger people
- adopt proactive approaches to risk management
- improve the recording of comorbidity and encourage coordination of physical healthcare and psychiatric care services

(This document was prepared by PHE. If adapting this for NI, leadership and advice would need to be provided by the relevant organisations such as PHA and HSCB.)*

Contribute to better understanding of drug related deaths and prevention via research and investigation:

- work with, compare and share lessons between, local areas where drug-related deaths are especially high or low or have significantly increased or decreased
- further investigate the relation of drug-related deaths to specific factors like mental health, domestic abuse, hospital admissions, and successful completion of drug treatment
- further investigate the relation between drug-related deaths and local and system-level factors like deprivation, the re-tendering of services, welfare reforms and payment of benefits

2017 Health Matters: preventing drug misuse deaths
https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

- Highlights identifying drug users in the community (eg via outreach, accessible locations & flexible hrs, NSE programmes, etc)
- Refers to NICE guidance re NSE programmes, pathway for drug misuse management, and to widening access to naloxone (PHE guidance)
- Outlines actions for local authorities and NHS, drug services, primary and secondary care

DePaul: Premature ageing in Homeless population February 2018
https://ie.depaulcharity.org/sites/default/files/Depaul%2C%20Premature%20Ageing%20Report%20Feb%202018_0.pdf

- Provide supportive and healthy shared living environment
- Provide emotional and motivational support
- Holistic, harm reduction approach to health and addiction needs (meet medical/health needs to people in own accommodation)
- Work in conjunction with statutory services to ensure all social and complex health needs, both mental and physical, are addressed

NICE Alcohol-use disorders: diagnosis and management Quality standard [QS11] (August 2011) https://www.nice.org.uk/guidance/QS11

- Statement 1: Health and social care staff receive alcohol awareness training that

promotes respectful, non-judgmental care of people who misuse alcohol.
- Statement 2: Health and social care staff opportunistically carry out screening and brief interventions for hazardous (increasing risk) and harmful (high-risk) drinking as an integral part of practice.
- Statement 3: People who may benefit from specialist assessment or treatment for alcohol misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.
- Statement 7: Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.

NICE Drug use disorders in adults Drug use disorders in adults Quality standard [QS23] (November 2012) https://www.nice.org.uk/Guidance/QS23

- Statement 1: People who inject drugs have access to needle and syringe programmes in accordance with NICE guidance.
- Statement 2: People in drug treatment are offered a comprehensive assessment.
- Statement 3: Families and carers of people with drug use disorders are offered an assessment of their needs.
- Statement 4: People accessing drug treatment services are offered testing and referral for treatment for hepatitis B, hepatitis C and HIV and vaccination for hepatitis B.
- Statement 9: People who have achieved abstinence are offered continued treatment or support for at least 6 months.

NICE NG64 Drug misuse prevention: targeted interventions (February 2017)
https://ie.depaulcharity.org/sites/default/files/Depaul%2C%20Premature%20Ageing%20Report%20Feb%202018_0.pdf

- Deliver drug misuse prevention activities for people in groups at risk through a range of existing statutory, voluntary or private services
- Complete assessment whether someone is vulnerable to drug misuse at routine appointments and opportunistic contacts with statutory and other services
- Involve service users in discussions to make informed decisions about their care
- Adults assessed as vulnerable to drug misuse should be offered clear information on drugs and their effects; advice and feedback on any existing drug use; information on local services and where to find further advice and support and this information should be provided at the same time as the assessment.
- Consider providing information about drug use in settings that groups who use drugs or are at risk of using drugs may attend.
- Consider providing information in different formats, including web-based information (such as digital and social media) and printed information (such as leaflets).

Advisory Council on the Misuse of Drugs (2019) Drug Related harms in Homeless populations and how they can be reduced
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf

Homeless population – varied and with complex needs, those using drugs:

- lack of social connectedness and greater risk for personal safety (especially users of synthetic cannabinoid receptor agonists (SCRAs)); experience of multiple adverse childhood experiences (ACEs);
- needs of people who are homeless, particularly rough sleepers, are not well met by mainstream benefit, health and social care and some drug services;
- higher rate of drug-related deaths and mental ill-health strongly associated with homelessness as both a cause and a consequence;
- Physical health: serious bacterial infections among IV drug users; high levels of HIV, HCV, and long-term chronic conditions (eg COPD);

- high rates of multiple morbidities, ie severe mental illness and long term physical health conditions;
- varied subpopulations: women, older people, young people, sex workers, offenders and ex-service personnel – with specific patterns of multiple oppressions and discriminations (eg females – sexual abuse, domestic violence histories), substance misuse (ex-service personnel – alcohol).

Recommendations

- Services at a local level must be tailored to meet the specific needs of substance users who are currently experiencing, or have recently experienced, homelessness – including evidence based and effective harm reduction and substance use treatment approaches with the capacity, resource and flexibility to reach them. Services need to consider people who are experiencing multiple and complex needs and adopt psychologically-informed approaches.
- Evidence-based Harm Reduction models in the UK include assertive outreach programmes, education, counselling, health promotion, peer support, user fora, needle exchange schemes, administration of Naloxone and opioid substitute prescribing.
- Substance use, mental health and homelessness services must use evidence-based approaches such as integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments such as opiate substitution treatment.
- Service providers should be aware of the levels of stigma experienced by people who are homeless and are engaged in substance use treatment or who choose not to engage due to the experiences of stigma and oppression they have had. Respect, choice, dignity and the uniqueness of the person should be at the core of the design and delivery of the service provision in respect of substance use and homelessness services. (eg professional values of respect, being non-judgmental, warm, empathic and compassionate approach).
- Involve service users in service design and implementation.
- The workforce in substance use and other services which have contact with the homeless need to have skills in dealing with complexity and in retaining homeless drug users in treatment.

Need for:

- Coordinated and integrated care for homeless people who experience complex and multi-faceted problems.
- Early detection and treatment to improve treatment outcomes and quality of life for those most in need of a holistic programme of intervention.
- Specialist targeted approaches for mental health, physical health and substance use using a more collaborative working model for outreach services and assertive outreach key to provide an effective service for those hard-to engage

Adams- Guppy (2014) A systematic review of interventions for homeless alcohol-abusing adults

A range of interventions were effective in reducing alcohol use and abuse within samples of homeless participants, although short-term effects are more apparent than longer term ones.

Further reading – *see also on same issues:*

Public Health England (2018). Drugs commissioning support: principles and indicators https://www.gov.uk/government/publications/alcohol-drugs-and-tobacco-commissioning-support-pack/drugs-commissioning-support-pack-2019-to-20-principles-and-indicators

Public Health England (2018). Alcohol commissioning support: principles and indicators https://www.gov.uk/government/publications/alcohol-drugs-and-tobacco-

commissioning-support-pack/alcohol-commissioning-suport-pack-2018-to-2019-principles-and-indicators

Any identified gaps

- Lack of data for Northern Ireland – need to collate data, establish trends and gather evidence
- Stability of service provision for service users accessing service provision
- Lack of a targeted service towards women as a priority group as well as rural focus issues
- Need for closer working with mental health and multi-agency to enable a holistic, individual centre approach
- Consider the increasing number of service users with complex needs, requirements for dual diagnosis can be addressed through development of appropriate pathways and partnership working
- Lack of a crisis response service within LTS given the increasing number of chaotic service users and those with complex needs
- Flexibility of service to meet the needs of service users and changing trends to include outreach and floating support – stop gap between stepping up and stepping down
- Services unspecific to the needs of the local homeless population (to include those living on streets, in temporary or unsuitable accommodation), no a local and regional perspective in the delivery of service to reduce the risk of escalating harmful behaviours – particularly in women who develop drug habits later but behaviours can escalate more quickly than in men
- Need to increase investment in harm reduction – services have been under-funded and there has been limited and reduced investment in harm reduction and public health interventions – proactive planning will provide more long-term sustainable investment
- Need to encourage continued engagement as there is evidence to support reduction in harmful behaviours by those who continue to engage in services over longer periods

Future approach to reflect the evidence base
(e.g. Changes in evidence base / key recommendations / evidence of impact)

- Baseline data to be agreed and collated consistently across all commissioned service providers at commencement of service to establish service user profiles (gender, age, etc) and to provide trends of (changing demographic profile, needs, etc.)
- Single point of entry for service users enabling stability of service provision and support to access referral pathways/service regarding (Trust) waiting lists
- Development of assessment pathway that can be used by commissioned service provider of the LTS as well as through opportunistic contacts with service users and those vulnerable to drug and/or alcohol misuse
- Provision of a flexible mixed service model for drugs and alcohol which is person centred and responsive to change in trends/demographic profiles
    - outreach services vary depending on the substance use pattern (alcohol only/drug only/drug and alcohol/poly drug)
    - aware of gender/age trends to meet needs of individuals, eg targeted service towards women as a priority group (eg female specific interventions and support to meet the needs of this younger female population); homelessness; rural issues; increasing number of service users with complex needs
    - includes outreach and floating support as stop gap between stepping up and stepping down
- Tailor services to the needs of the whole range of local homeless population (including those living on streets, in temporary or unsuitable accommodation) with a local and regional perspective in the delivery of service to reduce the risk of escalating harmful behaviours – particularly in women who develop drug habits later but behaviours can

escalate more quickly than in men

- Need to integrate services in a holistic manner – wrap around services offer health; hygiene; nutrition; support to engage with other agencies, including housing and social care; closer working with mental health and multi-agency to enable a holistic, individual centre approach
- Need to accommodate a crisis response service given the increasing number of chaotic service users and those with complex needs
- Encourage continued engagement as those who continue to engage in services over longer periods show reduced harmful behaviours