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

Joan Crossey

Public Health Agency

Lisburn Health Centre

Linenhall Street, Lisburn BT28 1LU

Telephone 028 9250 1259

commissioningframeworkconsultation@hscni.net

YOUR RESPONSE MUST BE RECEIVED BY 11th April

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

on behalf of an organisation ☐

Name: Dr Philip McGarry

Job Title: Chair

Organisation: Royal College of Psychiatrists in Northern Ireland

Address: Clifton House, 2 North Queen Street, Belfast, BT15 1ES

Tel: (028) 90278793

Email: tmckeever@rcpsych.ac.uk

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?

We are in agreement with the overall aim of the consultation document. We as a Medical College of treating Psychiatrists are in an excellent position to provide a broad scope of healthcare opinion. We strongly support the standardization of approach across Northern Ireland with the local scope to address area specific issues. The development of regional Care Pathways to encourage best practice in Northern Ireland is to be lauded.

Our overall major question that requires consideration throughout the document is…What are the hard outcome measures and how exactly are they going to be measured and who is going to resource the measuring of these outcomes?

SECTION ONE: CHILDREN, YOUNG PEOPLE AND FAMILIES

Drugs and Alcohol

While the Addiction Faculty do not treat children directly in our day to day work, we recognise the impact of Adult Services on them. We strongly feel that the restriction of availability of alcohol for young people is as important as it is for older members of society…thus restricting pricing and availability are key factors. “The strongest evidence for measures which reduce alcohol related harm at a population level are those which attempt to regulate the alcohol market through pricing / taxation and restricting supply.” (From page 40 section 8.2.1)

We make no specific response regarding this section otherwise.

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

While agreeing with the general thrust of the commissioning priorities, we feel these do not go far enough and are not specific enough. We encourage the Legislature to push forward with more specific aims including appropriately funded outcome measurements.

We would also encourage the Legislature to explain clearly the rationale behind minimum pricing and restriction of Over the Counter Opioid and both prescription and illicit drugs to promote a shift in public perception to minimise their adverse impact of the use of these substances on the population.

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

Yes

8.4 Early Intervention Services

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

Yes

We are in support of reaching out to increasing populations with drug and alcohol problems. We recognize that Statutory Addiction Services only see the more dependent end of the spectrum of problem drug and alcohol use. We feel that while a Local Enhanced Service can be of benefit, it would be worthwhile financially incentivising the whole of General Practice to deliver Screening and Brief Interventions.

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

Yes

AUDIT is a gold standard for identification of harmful drinking, however it may be undeliverable given the time pressures in Primary Care; a tool like CAGE may be a more practical alternative. The target groups are appropriate in our opinion.

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

Yes, but note the opinion expressed at the start of our response.

8.11 Substance Misuse Liaison Services

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

Yes

We strongly support the introduction of Substance Misuse Liaison Practitioners as opposed to limiting this role to Alcohol. We do strongly feel that given the likelihood of large overlap with Unscheduled Care Services that these practitioners should be Mental Health Trained Nurses.

Investing money at this pivotal point in a harmful/hazardous drinker's life will undoubtedly save money for the health service in the long run.

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

Yes

We do however point out that finding cases oneself is problematic; education of A&E staff to refer appropriate individuals seems much more rational to our thinking. However we feel the main priority of these practitioners should be to deliver Brief Interventions.

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

Yes, but note the opinion expressed at the start of our response.

8.20 Low Threshold Services

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

Yes

We agree that Low Threshold Services are vital and would like to extend their role in initiating BBV testing and procurement of vaccination; this should be a priority for ALL healthcare providers. Alcohol related Brain Injury costs a disproportionately huge sum in long term care, provision of Community based nutrition, i.e.at least one meal a day will reduce this in a very meaningful way.

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

Yes

We agree strongly with community based take home Naloxone services.

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

Yes

In addition, a rise in the numbers of Tier 3 attendances should be a measurable outcome for these services.

8.28 Community Based Treatment and Support

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

Yes

However we would point out that there are a percentage of Opioid Dependent individuals, i.e. OTC Opioid users, who should not be offered Naloxone as it would be inappropriate. (Last Local Commissioning point)

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

Yes

In addition we recommend the insertion of

-Pharmacological interventions to aid ongoing alcohol and/or drug abstinence

(Under 8.30.3)

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

Yes

Although hard outcome measures will be required with resources to measure these.

8.41 Inpatient and Residential Rehabilitation Provision

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

Yes

As a College we accept that resources have shrunk in line with the contraction of overall budget for health services. We feel that it is unfortunate that there is no inpatient provision in the Western and Southern Areas of the province. This is based on the idea of equal access to treatment for all. It is important that these beds will be for the disposal of appropriate Tier 3 patients through regionally established care pathways.

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

Yes

We wish to raise a point about ensuring that acutely mentally unwell patients are not appropriate for Tier 4 substance misuse service beds. They are of course entirely appropriate once their acute illness has passed.

We feel that driving only numbers through service is not the most appropriate outcome measure; that a qualitative measure must also have considerable bearing on the success of the service concerned.

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, we feel that learning from strong bases of successful longer term outcomes, e.g. The Ex-Patients group from Ward 15, should be taken into consideration.

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

Yes

Working in Partnership with Service Users and Carers is core to the RCPsych method of working and we would be happy to provide some Experts by Experience for talks from a National perspective if this was felt helpful.

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

Yes

We feel that the offering of Family Work should be an outcome of this commissioning.

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

We recommend REGIONAL outcome measures be established.

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

Yes

The document identifies the demands placed on services by the consequences of the harmful use of alcohol. These include admissions to acute general hospital and psychiatric beds of people who have sustained brain damage and have cognitive impairment secondary to alcohol misuse. Alcohol related brain damage is largely

under diagnosed and is estimated to be present in up to 30% of alcohol dependent individuals.

This group of patients are likely to relapse into alcohol misuse and require readmission for detoxification and associated physical symptoms. This cyclical pattern of admissions is likely to recur. The complexity of their needs often results in delays in discharge from hospital. There is clear evidence that the provision of an appropriate rehabilitative service for this patient group results in reduction in acute hospital bed day usage by 85%, dramatically improves quality of life in individuals and is able to maintain 75% of affected patients in non-institutional community settings.

It has been demonstrated elsewhere that by providing a service for this group of patients that there are financial benefits including the reduction in bed occupancy and improved health and social wellbeing.

It has been estimated that a population of approximately 300,000 people would receive an estimated 3 referrals to such a service per month. An audit ongoing in the Belfast Trust acute admission wards has to date identified 80 patients in just less than four months that show evidence of cognitive impairment in association with harmful use of alcohol (preliminary findings).

It is important that the 4 tier model described takes into account the needs of this group of patients with a clear care pathway to an appropriate specialist service. We believe this could be provided in a model which is not resource intensive and could lead to significant financial and health benefit.

We recommend looking at a bench mark services such as the pioneering model in the Wirral, Liverpool.

Reference:

Cook C, Hallwood P, Thomson A. B Vitamin deficiency and neuropsychiatric syndromes in alcohol misuse. (1998), Alcohol and Alcoholism Vol. 33, 317-336.

Wilson K. (2011) Alcohol related brain damage: a 21st century management conundrum. The British Journal of Psychiatry.199, 3, 176-177.

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.

The Royal College of Psychiatrists in Northern Ireland welcomes the opportunity to respond to this Consultation regarding the Alcohol and Drug Commissioning Framework for Northern Ireland 2013-2016

The Royal College of Psychiatrists is the statutory body responsible for the supervision of the training and accreditation of psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care and prevention of mental and behavioural disorders.

The College has 320 members in Northern Ireland, including doctors in training. These doctors provide the backbone of the local psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

These views represent the opinion of the Northern Ireland Addiction Faculty in consultation with Members of the Royal College of Psychiatrists in Northern Ireland Executive.