Northern Ireland Audit Office

Addiction Services in Northern Ireland

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
30 June 2020

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Published 30 June 2020

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K J Donnelly CB
Comptroller and Auditor General

Northern Ireland Audit Office
30 June 2020

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Contents

List of Abbreviations

A&E	Accident and Emergency
ACMD	Advisory Council on the Misuse of Drugs
ACT	Alcohol Care Team
ARBI	Alcohol-related brain injury
BSO	Business Services Organisation
DACT	Drug and Alcohol Co-ordination Team
DoJ	Department of Justice
HSCB	Health and Social Care Board
IMT	Impact Measurement Tool
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Health and Care Excellence
NSD	New Strategic Direction for Alcohol and Drugs
OST	Opioid Substitution Therapy
PHA	Public Health Agency
PHE	Public Health England
PSNI	Police Service of Northern Ireland
RATN	Regional Addiction Treatment Network
SMD	Substance Misuse Database
SMLN	Substance Misuse Liaison Nurse
SPS	Substitute Prescribing Service
WNDSM	Welsh National Database for Substance Misuse

Key Facts

Up to £900 million	Estimated cost of alcohol misuse per year in Northern Ireland
£8 million	Annual budget for implementation of drug and alcohol strategy
£33 million	Estimate of the annual cost of A&E attendances due to alcohol misuse
200	Hospital beds are occupied every day on average where substance misuse was recorded as a contributing factor
203%	Increase in drug misuse deaths in the last decade
6,743	People receiving treatment for substance misuse at 30 April 2019
284	Deaths due to alcohol misuse in 2018
980%	Increase in deaths related to pregabalin from 2014 to 2018
2 years	Since last Substance Misuse Database was published

Executive Summary

Executive Summary

Despite the significant costs related to substance misuse, a small budget is allocated to tackling the issue

1. Substance misuse can cause a wide range of harm to the individual, their family and wider society. It is estimated that alcohol misuse alone costs up to £900 million per year in Northern Ireland, including £250 million of costs borne by the Health and Social Care sector. Despite these significant costs, the Department of Health (the Department) allocates a small budget to tackling these issues each year, £8 million for implementing its alcohol and drug strategy and £8 million towards statutory addiction services.

2. Every day in Northern Ireland, an average of 200 hospital beds are occupied where substance misuse was recorded as a contributing factor. The number of bed days occupied where there was a primary diagnosis of mental and behavioural issues due to substance misuse has increased by over 35 per cent in the last five years. In comparison, in England, these bed days have decreased by almost one quarter over the same period.

The level of harm caused by substance misuse is high and rising

3. The numbers seeking treatment for drug misuse have increased significantly from 2,107 in 2007 to over 4,100 in 2019. Over the same period drug misuse deaths in Northern Ireland have increased by more than 200 per cent. Alcohol misuse deaths have increased by more than 40 per cent since 2013 in Northern Ireland, more than anywhere else in the United Kingdom.

4. Addiction services are facing significant and growing pressures, including the increasing complexity of care required, an ageing cohort of service users and co-existing mental health issues which make management of treatment more complicated. Services are also under increasing strain, in particular where waiting lists for some services have been in excess of a year. Whilst this situation has improved, in part due to non-recurrent funding to address the issue, there are still a significant number of people waiting to access statutory addiction services in Northern Ireland at any given time.

5. Excessive waiting times can deter people from seeking treatment and negatively influence health outcomes for service users. The Substitute Prescribing Service has experienced particularly long waiting lists, although extra investment has recently reduced these. The Department has held a long-standing ambition to share responsibility for this care with primary care, in order to normalise care for service users and reduce the pressure on statutory addiction services, but this has not been successful.

6. Residential care has been partly reviewed and regionalised. While this has been broadly successful for detoxification and stabilisation, more work is required to ensure that there is equitable access to rehabilitation beds, in particular securing access for service users in all Trust areas. Referral pathways from statutory addiction services to rehabilitation providers are inconsistent and should also be reviewed.

The Department has little information on outcomes for service users

7. The Department's performance monitoring of substance misuse services is very limited. Data collected is not reliable or complete, therefore the Department cannot demonstrate that services are effective or delivering value for money for the taxpayer. The Department's Substance Misuse Database has not been published for over two years due to quality issues.

8. The Department has little information on outcomes for service users. The data collected is largely activity based, rather than focusing on outcomes. Whilst we acknowledge that this information can be difficult to collect, ultimately the Department's data should focus on the impact services have on people's lives rather than the numbers coming through the door.

Value for Money Conclusion

9. Whilst our audit noted some cost effective initiatives aimed at reducing the harms related to substance misuse, the Department has little reliable information on the outcomes for service users. It is therefore not possible to determine whether public funding spent on addiction services provides value for money or whether service users are getting the best possible outcomes.

Scope

10. Our investigation has focused on the services delivered by healthcare providers to those affected by drug and alcohol misuse. However, it is clear from our work that a joined up approach encompassing the whole of government is required to fully tackle this issue.

11. This report was completed before the outbreak of COVID-19. To ensure that audit work did not disrupt the efforts of severely stretched public bodies dealing with a most challenging set of circumstances, the NIAO took a conscious decision not to publish during the pandemic even though the report had been finalised.

Part One:
Introduction

Part One:
Introduction

1.1 Substance misuse can cause a wide range of harm to the individual, their family and wider society. This can impact on the individual's physical and mental health, unemployment, homelessness and criminal activity. There are also high economic and human costs associated with substance misuse.

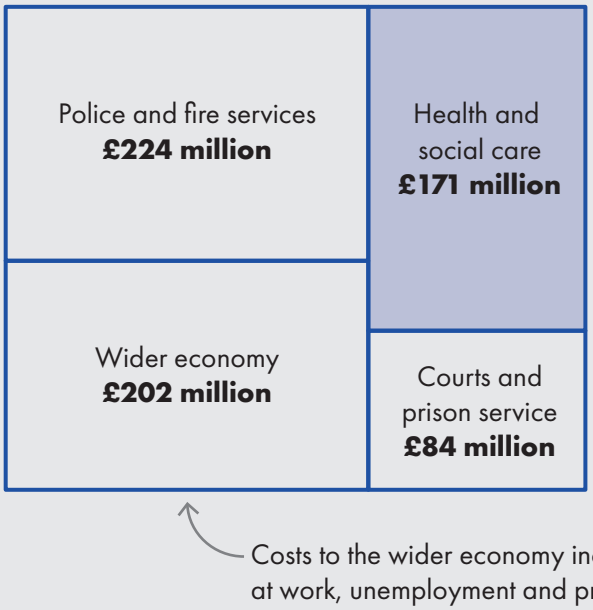
1.2 Substance misuse is a complex issue and does not occur in isolation. Many factors contribute to substance misuse and related harms. Recovery involves more than helping people to overcome their dependency. It includes addressing a range of needs which are critical in supporting people to progress towards and maintain a life free from substance misuse. Service users may need support with housing, family and relationships, employment and the criminal justice system.

Substance misuse results in significant costs to the public sector and wider society

1.3 In 2009, the Department of Health (the Department) estimated that alcohol misuse costs around £680 million per annum in Northern Ireland. This includes £171 million of direct health and social care costs; £224 million of fire & rescue and police service costs; £84 million of courts and prisons costs; and £202 million of costs to the wider economy (see **Figure 1**). Estimates by the Department suggest that costs may have risen to £900 million per annum by 2014, £250 million of these borne by the Health and Social Care sector. To date there are no equivalent estimates for the costs of drug misuse in Northern Ireland.

Figure 1. Alcohol misuse results in significant costs

In **2009**, the Department estimated that alcohol misuse in Northern Ireland costs around £680 million per year. Around one quarter of these costs fell directly on the health and social care system.



Source: Department of Health

1.4 Substance misuse also imposes substantial costs on other parts of the public sector. The criminal justice system, for example, experiences significant costs in dealing with crime and court proceedings related to substance misuse. Alcohol related crime makes up a substantial proportion of violent offences in Northern Ireland. It was a contributing factor in just over 14,000 offences in 2018-19, around 40 per cent of all violent crime.[1]

1.5 The Department estimates that £224 million per annum is incurred by the fire & rescue and police services dealing with alcohol related callouts and crime, whilst costs to the courts and prison services were estimated to be more than £83 million per annum, including the costs of legal aid, public prosecution costs and the costs of prisoners serving custodial sentences for alcohol related crimes.[2] The Police Service of Northern Ireland (PSNI) reports that drug seizure incidents have increased by almost 50 per cent in the five years to March 2019, with over 7,000 seizures in 2018-19, the highest level ever recorded in Northern Ireland. Drug related arrests have also increased significantly over the last five years.

1.6 Substance misuse also generates a range of cost impacts in the wider economy. The Department estimated that over £200 million per annum of alcohol related costs are incurred by the wider economy, including the costs of absenteeism at work, unemployment and premature mortality due to alcohol related conditions.

1.7 Despite these significant costs to the public sector, a relatively small budget is allocated to tackling the problem by the Department of Health. In terms of direct funding, the Department allocates £8 million per annum for implementation of the New Strategic Direction for Alcohol and Drugs. It also allocates £8 million per annum for statutory addiction services from the mental health budget, representing 5 per cent of the total mental health budget.

The level of harm caused by substance misuse in Northern Ireland is high and rising

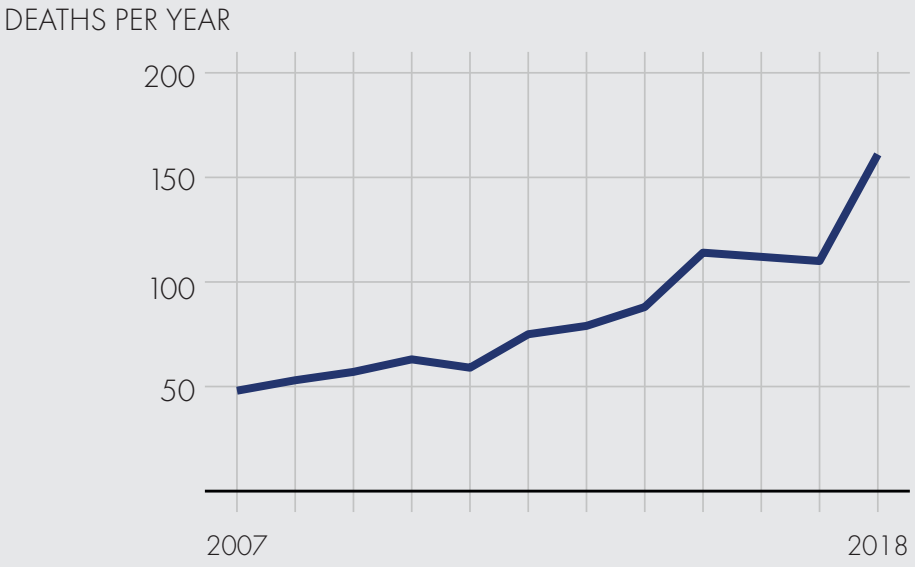
1.8 Whilst alcohol remains the substance that causes most deaths locally, the level of drug related harm has increased significantly in Northern Ireland over the last decade. The number of drug related deaths has more than tripled from 53 in 2008 to 161 in 2018 (see **Figure 2**).

1 Police Recorded Crime Statistics in Northern Ireland 1998-99 to 2018-19

2 DHSSPS, Social Costs of Alcohol Misuse in Northern Ireland (2008/09)

Part One:
Introduction

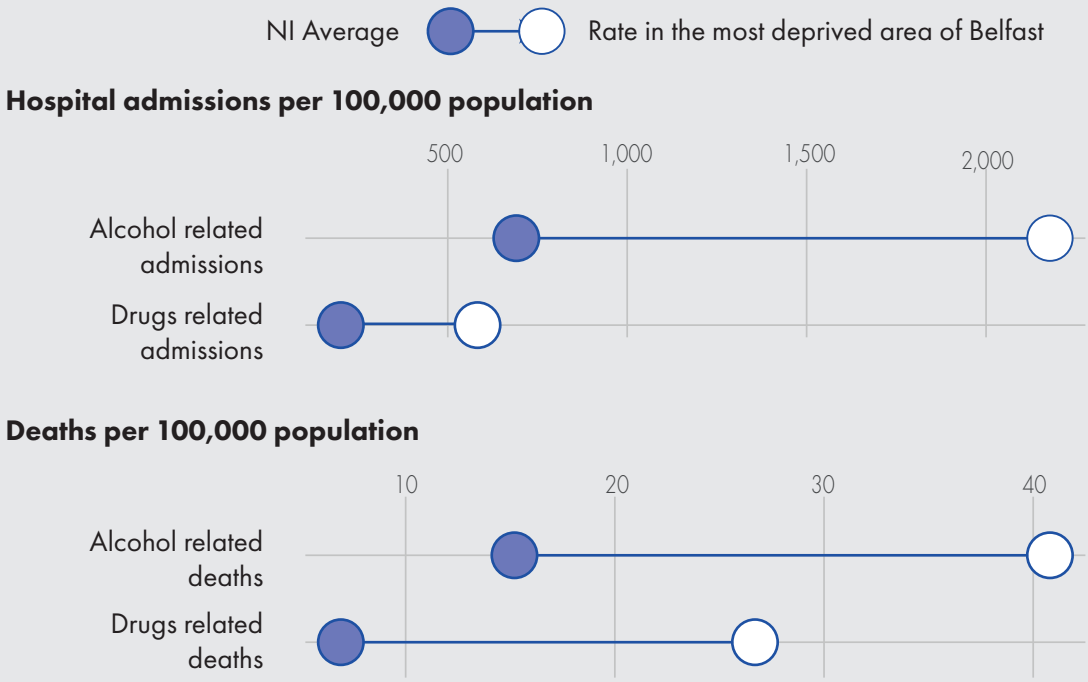
Figure 2. The number of deaths due to drug misuse increased by over 230 percent between 2007 and 2018



Source: NISRA

1.9 Some of the largest health inequality gaps in Northern Ireland are related to alcohol and drugs. In the most deprived areas alcohol and drug related deaths are around four and a half times the rates seen in the least deprived. Alcohol and drug related hospital admissions reflect similar inequalities. In the most deprived areas admissions are around four times the rate than in the least deprived areas. Some of the largest inequalities are in the Belfast Trust area (see **Figure 3**).

Figure 3. Some of the largest health inequalities related to drugs and alcohol are seen in the Belfast Trust area



Source: Department of Health, Health Inequalities Annual Report 2019

1.10 The numbers presenting for substance misuse treatment have increased significantly in the last decade, although this is likely to underestimate the scale of the problem. At 30 April 2019, 6,743 people were in treatment[3] for substance misuse. This represents an increase of 21 per cent since 2007 and 13 percent over the last two years.

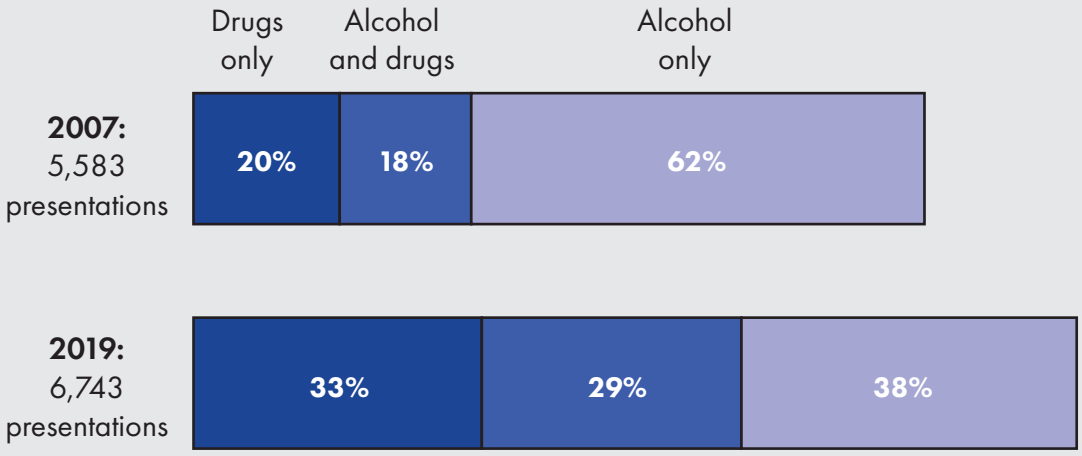
1.11 Whilst demand for services has increased, the majority of this relates to people seeking treatment for drug misuse (see **Figure 4**). In 2019, there were 4,183 people in treatment for problem drug use, compared to 2,107 in 2007, an increase of more than 98 per cent over the period.[4]

3 The number of people in treatment is defined as "live cases" where individuals are being seen on a one-to-one basis.

4 Census of Drug and Alcohol Treatment in Northern Ireland, Department of Health, (September 2019).

Part One:
Introduction

Figure 4. There has been a significant increase in the proportion of people who present for drug misuse treatment



Source: Department of Health

Whilst alcohol misuse remains the most prevalent substance issue in Northern Ireland, the nature of drug misuse is changing

1.12 Addiction services have witnessed a significant escalation in the demand for drug misuse treatment, in particular treatment relating to heroin use. Patterns of drug use have also changed, with the misuse of prescription drugs and polydrug misuse[5] being significant factors.

1.13 Misuse of prescription drugs means taking a medication in a manner or dose other than prescribed, taking someone else's prescription, or taking a medication to feel euphoria. Prescription drug misuse can have serious medical consequences including the risk of overdose and addiction. There are a number of prescription drugs that are particularly susceptible to misuse and appear to contribute to drug related harm in Northern Ireland. The changing nature of drug misuse is discussed further in Part Three.

5 Polydrug use is when a person uses more than one type of drug, either at the same time or at different times. Polydrug use occurs when a person:

- uses two or more drugs in combination
- uses one drug to counteract the effects (or the after effects) of another
- uses different drugs at different times over a short period of days or weeks.

The strategy for reducing the harm related to alcohol and drug misuse is due to be updated

1.14 The Department has overall strategy development and evaluation responsibility for alcohol and drugs and launched its New Strategic Direction for Alcohol and Drugs (NSD) Phase 2 2011-16 in March 2012. The strategy sets out a number of objectives in relation to substance misuse in Northern Ireland. The original NSD covered the five-year period 2006-2011, but the Department considered this too short a timeframe to have a significant impact and so the strategy was revised and extended to 2016.

1.15 The Department reviewed the strategy in 2018 and published its findings in early 2019. The review concluded that:

- Whilst progress had been made on a number of population level indicators, the pressure on services, specifically the demand for Substitute Prescribing Services, and increases in alcohol and drug related deaths, were of particular concern.
- Data from the Impact Measurement Tool (IMT) did not meet the requirements for publication as an official statistic and data quality issues remain (see Part Five).
- The gap between finalising the strategy and procuring services meant that there had been little time for new services to become embedded and make a real difference to individual and population level outcomes.

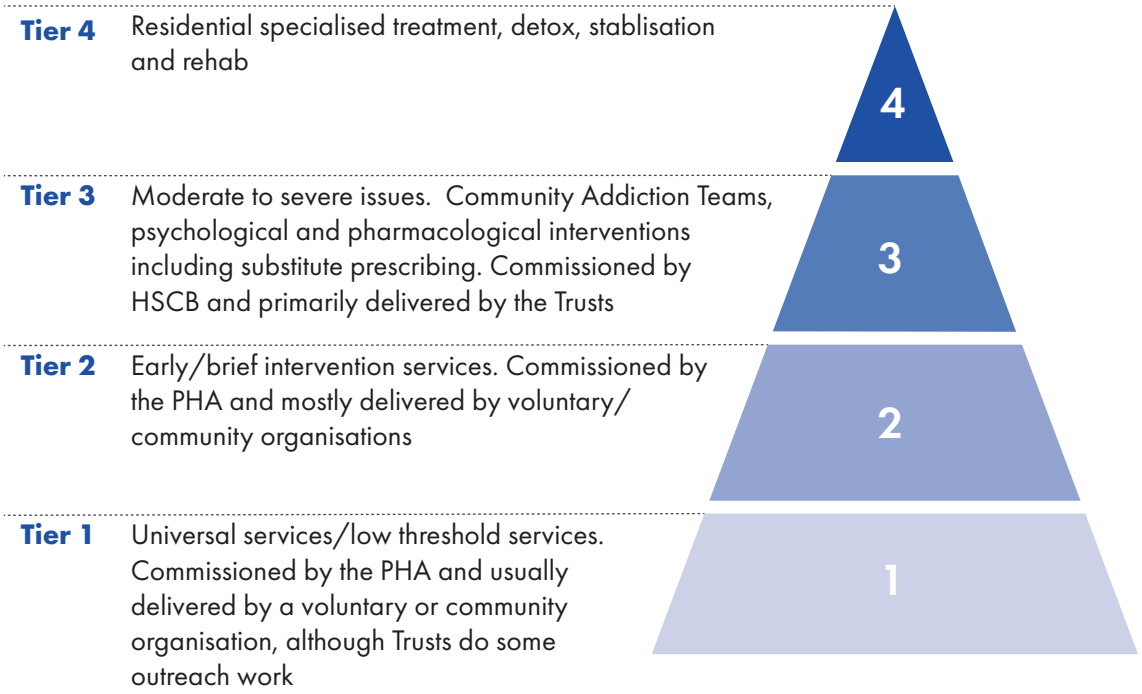
1.16 The Department told us that it has completed a pre-consultation exercise seeking views on what should be included in any new substance misuse strategy and established an advisory group including representatives from the Department, service users, the Department of Justice/PSNI, the Public Health Agency (PHA), the Health and Social Care Board (HSCB), the Drug and Alcohol Co-ordination Teams, and the NI Alcohol and Drug Alliance. This work was originally due for completion by the end of September 2019, with findings shared with the NSD Steering Group by December 2019.

There are a number of bodies involved with alcohol and drugs services in Northern Ireland

1.17 Substance misuse services are structured in four tiers, in line with guidance provided by the NHS (see **Figure 5**). In Northern Ireland, lower tier services are normally commissioned from the voluntary and community sector, whilst interventions that are more intensive are procured from the Health and Social Care Trusts (the Trusts), usually through the Community Addiction Teams.

Part One:
Introduction

Figure 5. Substance misuse services are structured in four tiers



Source: Department of Health

1.18 Whilst the Department has overall responsibility for strategy development, the PHA provides expert advice to the Department; commissions services at Tiers 1 and 2 and supports the five local Drug and Alcohol Co-ordination Teams (DACTs) aligned to Trust areas. The HSCB is responsible for commissioning services at Tiers 3 and 4. There is an NSD Steering Group, chaired by the Chief Medical Officer, which is responsible for policy oversight and strategy delivery and monitors overall progress against the NSD's targets and outcomes.

Part Two:
Costs of Substance Misuse

Part Two:
Costs of Substance Misuse

The health sector incurs significant costs dealing with alcohol and drug misuse

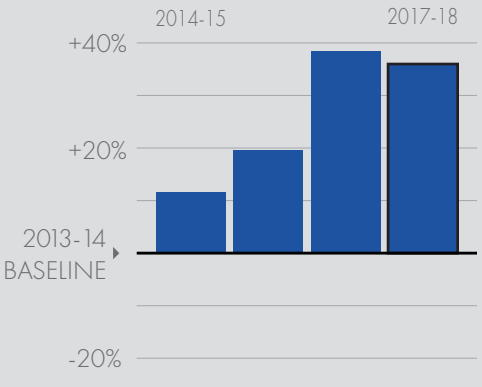
2.1 It is estimated that approximately 25 per cent of Accident and Emergency (A&E) department consultants' time is spent dealing with alcohol related incidents[6], with figures as high as 75 per cent being reported at peak times. Whilst some A&E attendances are one-offs, there is a small group of people who repeatedly present at A&E and account for a disproportionate level of hospital use and associated costs.

2.2 In 2018-19 there were 822,847 new and unplanned attendances at A&E departments in Northern Ireland[7]. Using the NHS reference cost of an A&E attendance (£160), and assuming a quarter of these were alcohol related, we estimate the cost of A&E attendances relating to alcohol misuse in Northern Ireland in 2018-19 to be almost £33 million.

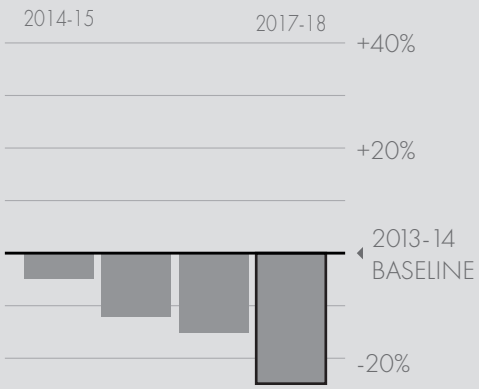
2.3 In 2017-18 there were over 14,600 admissions to Northern Ireland hospitals where there was a diagnosis of a condition wholly attributable to alcohol or drugs. The vast majority of these admissions involved alcohol (88 per cent) and almost 17 per cent involved drugs. Nearly 5 per cent involved both. At an average cost of over £1,500 per admission, the total cost of admissions where alcohol and drug related conditions were recorded was almost £23 million. Over 73,000 hospital bed days were occupied where substance misuse was recorded as a contributing factor in 2017-18. Whilst the majority of this relates to alcohol, this equates to 200 hospital beds occupied every day.

Figure 6. Hospital bed days due to mental and behavioural issues caused by substance misuse have increased by 35% since 2013-14 in Northern Ireland

In **Northern Ireland** there were 9,400 hospital bed days due to disorders caused by substance misuse in 2017-18



Over the same period the number of bed days for this reason in **England** decreased by 25%



Over the same period the number of bed days in Wales due to this reason fell by 9%.

Source: NIAO analysis of Department of Health statistics

6 Alcohol's Impact on Emergency Services, Institute of Alcohol Studies (October 2015)

7 Northern Ireland Hospital Statistics: Emergency Care (2018-19)

Substance Misuse Liaison Nurses can reduce A&E attendances and refer patients to specialist addiction services

2.4 Establishing a consultant-led, multidisciplinary Alcohol Care Team (ACT) and specialist alcohol liaison nurse services were two of the recommendations of the National Confidential Enquiry[8] into Patient Outcome and Death (2013) 'Measuring the units: a review of patients who died with alcohol-related liver disease'. This study highlighted delays in the referral of patients for specialist alcohol care, and missed opportunities for brief interventions during previous admissions.

2.5 The Belfast ACT was introduced in 2012, following a review that found over 20 per cent of A&E attendees were drinking at a high risk level and 50 per cent at a harmful level. Its role was to coordinate alcohol inpatient and outpatient care and develop strategies to reduce alcohol-related problems within the Trust.

2.6 Guidance from the National Institute for Health and Care Excellence (NICE) recommends that all patients admitted to an acute hospital should be offered alcohol screening, and that screening of all A&E attenders is highly desirable. Those patients identified as higher risk should be referred to the Substance Misuse Liaison Nurse (SMLN). SMLN services are based in all HSC Trusts and also provide brief interventions and advice, along with discharge planning and liaison with formal addiction services. Brief interventions are proven to be successful – one study concluded that for every two patients referred to a SMLN there will be one less A&E attendance within 12 months.[9]

2.7 There are two SMLNs covering the whole of the Belfast Health and Social Care Trust (Belfast Trust) area, a population of 340,000 with over 200,000 A&E attendances every year. Whilst funding has been made available for two additional posts, the amount of education and training provided by the SMLN has reduced significantly and it is not possible to provide seven day a week coverage. Patients with substance misuse related morbidity tend to access healthcare services on a recurrent basis, providing opportunities for them to be identified and referred to specialist addiction services for support. However, a review conducted by the Belfast ACT found that only 15 per cent of higher risk drinkers were being referred to SMLN services. As a consequence, opportunities to refer patients to appropriate addiction services are being lost.

2.8 The SMLN service is likely to change as a new model for mental health services within acute hospital settings is being developed. The SMLN role is expected to be included alongside other mental health professionals covering patients who present with self-harm, substance misuse, mental health or psychosocial crisis. There are some concerns that the expertise within the SMLN service will be lost when the new model is implemented.

8 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent body whose purpose is to assist in maintaining and improving standards of care by reviewing the management of patients, by undertaking confidential surveys and research.

9 Screening and referral for brief intervention of alcohol-misusing patients in an emergency department: a pragmatic randomised controlled trial, Crawford, MJ, et al., Lancet. 2004 Oct 9-15;364 (9442):1334-9.

Part Two:
Costs of Substance Misuse

Recommendation 1

In the context of the reorganisation of mental health services within acute hospital settings, the Department should ensure that it continues to raise awareness of substance misuse screening and referrals to substance misuse services.

Part Three:
The Changing Nature of Substance Misuse

Part Three:
The Changing Nature of Substance Misuse

Alcohol related harm is on the rise

3.1 Alcohol misuse remains the most prevalent substance misuse issue in Northern Ireland, with the most severe impact on health. Alcohol is a causal factor in more than 60 medical conditions, including mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression (see **Figure 7**).[10] A significant proportion of the health issues due to alcohol consumption arises from injuries, including those due to road traffic accidents; violence; and suicides.

Figure 7. Alcohol misuse contributes to significant health issues

HARMFUL ALCOHOL USE CAUSES	
48%	of liver cirrhosis
26%	of mouth cancers
26%	of pancreatitis
18%	of suicides
13%	of epilepsy

Source: World Health Organisation

3.2 Alcohol misuse can have long term health consequences, resulting in repeated attendances at emergency departments, frequent hospital admissions, and long term intensive healthcare interventions. Recent reports suggest that one in ten people in a hospital bed are alcohol-dependent and one in five are drinking at a harmful level.[11]

3.3 Diagnoses of alcoholic liver disease have also increased sharply in Northern Ireland. In 2011-12 there were 1,692 admissions at hospitals with a diagnosis of alcoholic liver disease. By 2017-18 this had increased to more than 2,500, an increase of almost 50 per cent.

Alcohol-related brain injury presents a significant healthcare challenge

3.4 Alcohol-related brain injury (ARBI) describes the effects of changes to the structure and function of the brain resulting from alcohol toxicity and vitamin deficiencies. It is an umbrella term covering a range of conditions that share common characteristics – the existence of cognitive impairment directly related to chronic alcohol consumption. Studies show that alcohol-related brain changes are present in 35 per cent of those with alcohol dependence as opposed to 1.5 per cent of the general population.

10 The public health burden of alcohol: evidence review, Public Health England (December 2016)

11 Society for the Study of Addiction (July 2019)

3.5 The cost of dealing with ARBI can be significant, due to acute bed occupancy and frequent attendance at emergency departments. In the absence of alternative treatment, ARBI patients are often placed in inappropriate and costly dementia care settings within nursing homes. A number of projects have been carried out in Northern Ireland to estimate the impact that ARBI has on healthcare services.

Case example 1: South Eastern Health and Social Care Trust

In 2016, the gastroenterology service carried out a retrospective review of ARBI cases encountered by their service over the previous five years. A random sample of 19 patients was selected. For this group, the number of hospital admissions over five years ranged from one to 37, with an average of 14.7 admissions per patient, and an average length of stay of 21.2 days. The Trust estimated that the average stay cost was £7,165. This equates to over £105,000 per person over a five-year period, and a total cost of just over £2 million for the 19 patients sampled.

Source: Alcohol-related brain damage in Northern Ireland, Royal College of Psychiatrists (April 2018)

3.6 ARBI has a relatively good prognosis – up to 75 per cent of patients make an improvement with abstinence and appropriate treatment. There is no standard or formal approach to treatment for ARBI patients, and no specific ARBI unit exists in Northern Ireland. Many patients end up in institutional settings for the rest of their lives. Providing specialist services would allow many of these patients to recover sufficiently to be transferred to less supported, and ultimately less costly placements. Leonard Cheshire, a charity providing supported living and community based services, is developing a new 14 bed facility in Belfast, focusing on residential rehabilitation for ARBI patients. This will be the first facility of its kind in Northern Ireland and is due to open in March 2020.

Alcohol misuse deaths have increased sharply

3.7 In 2017, 303 of the 16,036 deaths registered in Northern Ireland were due to alcohol related causes, the highest number ever recorded. Whilst this number fell to 284 in 2018, it remains almost 17 percent more than a decade previously. The number of alcohol related deaths is consistently higher among men, accounting for almost 70 per cent of the 2018 total. The largest number of alcohol related deaths occurs in those aged between 55 and 64 years.[12]

3.8 Alcohol misuse deaths have increased more in Northern Ireland than anywhere else in the United Kingdom - in the five years to 2017, alcohol related deaths increased by over 40 per cent in Northern Ireland. This is a significantly higher increase compared to the rest of the United Kingdom, where increases have ranged from six to nine per cent (**Figure 8**).

12 Alcohol Related Deaths 2008 – 2018, NISRA.

Part Three:
The Changing Nature of Substance Misuse

Figure 8: Northern Ireland has the second highest rate of alcohol related deaths in the UK

	2013	2014	2015	2016	2017
Northern Ireland	12.2	12.9	16.4	16.8	17.4
Scotland	19.0	19.5	19.5	21.1	20.5
Wales	12.7	11.5	11.9	12.7	13.5
England	10.2	10.5	10.3	10.5	11.1

Alcohol-specific death rates are expressed per 100,000 people

Source: Office for National Statistics

Prescription drug misuse is a growing issue in Northern Ireland

3.9 There are a number of prescription drugs that are particularly susceptible to abuse and appear to contribute to drug related harm (see **Figure 9)**. Many of the drugs that are abused are available on prescription, however, there are other means of acquiring them:

- Taking medication which is prescribed for someone else
- Illegal purchase

Misuse can also involve using medication prescribed to you in a way not intended by the prescriber.

Figure 9: There are a number of commonly misused prescription drugs

Diazepam

Diazepam is used to treat anxiety, alcohol withdrawal and seizures. It is also used to relieve muscle spasms and to provide sedation before medical procedures. It belongs to a class of drugs called benzodiazepines. Benzodiazepines work by slowing down activity in the brain and keeping the brain in a more tranquilised state.

Doctors recommend that patients should not be on these drugs for longer than four weeks as tolerance levels can develop causing an increase in dosage which eventually leads to addiction problems. Sudden withdrawal can be dangerous resulting in hallucinations and convulsions.

Tramadol

Tramadol is a strong opioid painkiller used to treat moderate to severe pain, for example after an operation or a serious injury. It is also used to treat long-standing pain when weaker painkillers no longer work. Tramadol works by blocking pain signals from traveling along the nerves to the brain. People who take tramadol for long periods and at high doses eventually develop a physical dependence and may experience unpleasant, dangerous withdrawal symptoms.

Gabapentinoids

Pregabalin

Pregabalin is an anti-epileptic drug, sometimes also prescribed to treat chronic pain and anxiety. It works by decreasing the number of pain signals that are sent out by damaged nerves in the body by slowing the impulses across the brain. Pregabalin is also called by the brand names Lyrica, Alzain, Lecaent and Rewisca.

Pregabalin can produce feelings of euphoria, relaxation and calmness. It can also increase the euphoric effects of other drugs, like opioids and can increase the risk of overdose when taken in this way.

Gabapentin

Gabapentin is used to treat epilepsy. It is also taken for nerve pain. Occasionally, gabapentin is used to treat migraine headaches.

Gabapentin has similar effects to drugs like benzodiazepines. It can also enhance the euphoric effects of other drugs, like opioids, and is likely to increase the risks when taken in this way.

3.10 The number of people presenting to substance misuse services who misuse prescription drugs is significant – according to the most recent Substance Misuse Database, one in five service users indicated that they took at least one prescription drug. A recent analysis[13] suggested that prescription opioid use is more prevalent in Northern Ireland than in the rest of the UK. Eleven per cent of treatment entrants in Northern Ireland cited 'other opioids' as their primary substance of misuse compared to 3.2 per cent in the rest of the UK.

The majority of drug related deaths involve prescription drugs

3.11 The number of deaths linked to prescription drug misuse is rising. These drugs are now involved in the majority of drug related deaths[14] in Northern Ireland. The two most common drugs to feature on death certificates are diazepam and tramadol; however, there has been a rapid

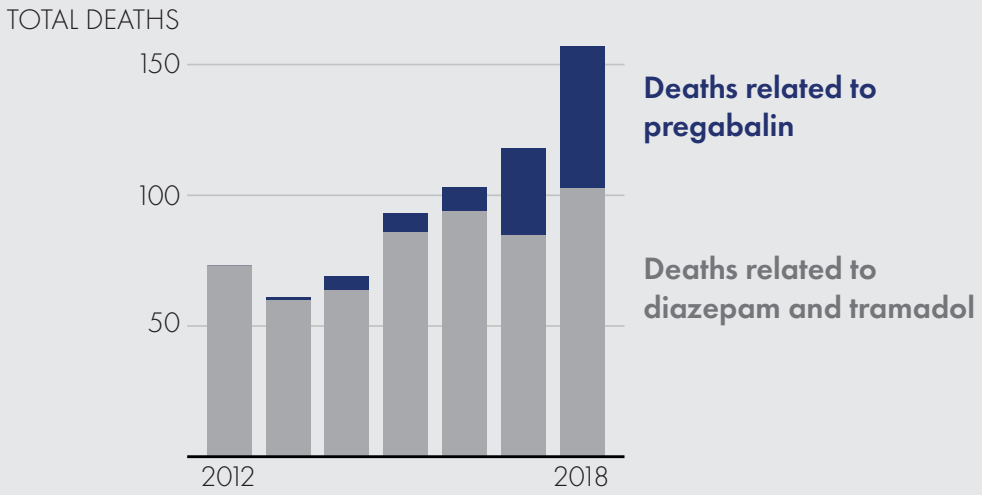
13 United Kingdom Drug Situation: Focal Point Annual Report 2017, UK Focal Point on Drugs, (March 2017).

14 A drug related death is one where the underlying cause of death recorded on the death certificate is drug poisoning, drug abuse or drug dependence.

Part Three:
The Changing Nature of Substance Misuse

increase in the number of pregabalin related deaths in the last five years (see **Figure 10**). Diazepam was detected in more than 40 per cent of drug related deaths in Northern Ireland in 2018.

Figure 10. Deaths related to prescription drug misuse in Northern Ireland are increasing

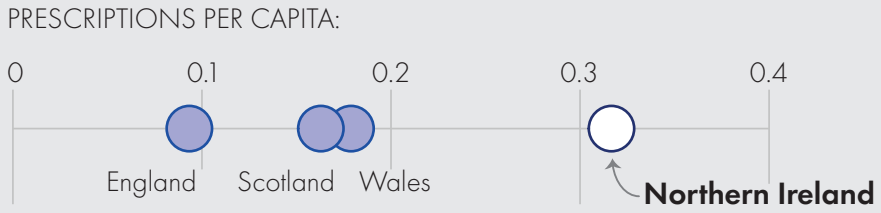


Source: NISRA

Northern Ireland prescribes more diazepam per capita than anywhere else in the UK

3.12 The number of prescriptions of diazepam in Northern Ireland has been quite consistent over the last five years. However the number of prescriptions per capita is significantly higher in Northern Ireland than anywhere else in the UK, and there are three and a half times as many prescriptions per capita as in England (see **Figure 11**).

Figure 11. There are three and a half times as many prescriptions of diazepam per capita in Northern Ireland as in England



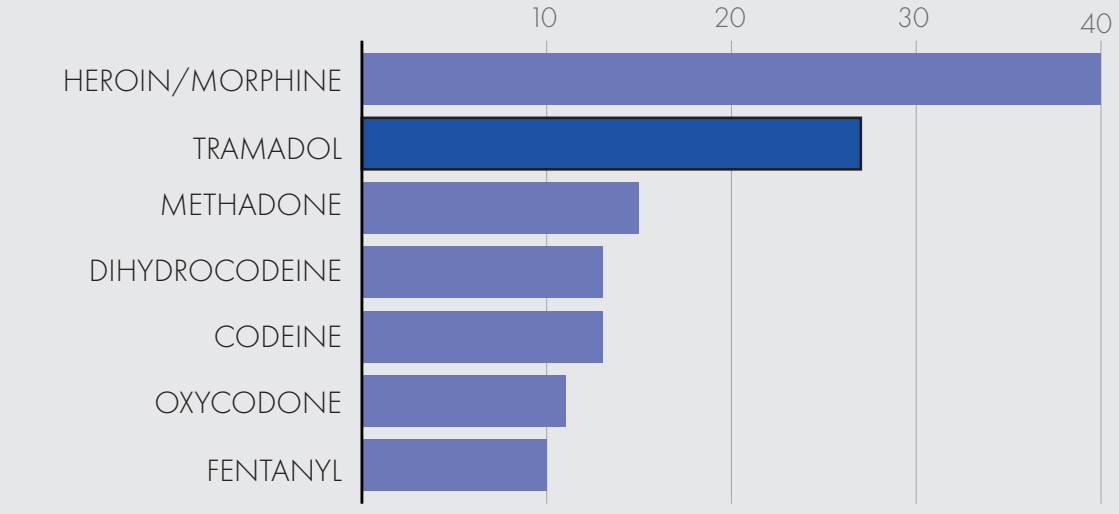
Source: NIAO analysis of BSO data

Strong opioids are prescribed more frequently in Northern Ireland than elsewhere in the UK

3.13 HSCB guidance on opioid prescribing[15] for Northern Ireland recommends that modified release morphine is the first line strong opioid for maintenance of pain control. However, when compared with other parts of the UK, it is evident that the prescription of morphine as a proportion of all strong opioids in much lower in Northern Ireland than other parts of the UK, and other strong oral opioids, such as oxycodone and tramadol, are prescribed much more frequently.

3.14 Tramadol, a strong oral opioid, was mentioned in 27 drug related deaths in 2018, an increase from 20 in 2013. Significantly, tramadol is mentioned more frequently on death certificates in Northern Ireland than any other opioid drug, except for heroin (see **Figure 12**). A high level comparison shows that tramadol was mentioned in 14 per cent of drug related deaths in Northern Ireland in 2018, compared to just seven per cent in England, Wales and Scotland.

Figure 12. Tramadol is mentioned more frequently on death certificates than any other opioid drug apart from heroin



Source: NISRA

15 http://www.hscboard.hscni.net/download/PUBLICATIONS/pharmacy_and_medicines_management/correspondence/Opioid-Prescribing.pdf

Part Three:
The Changing Nature of Substance Misuse

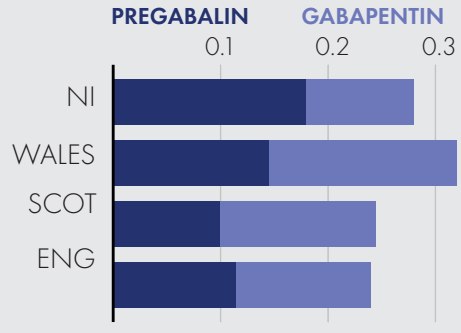
Northern Ireland prescribes more pregabalin per capita than any other part of the UK

3.15 Recently, concerns have emerged about the misuse of gabapentinoids, including pregabalin, and their role in drug related deaths. Where gabapentinoids are misused, they are often not the primary drug of misuse. Those who misuse opioids often use gabapentinoids to achieve a quicker high and reduce withdrawal symptoms from other drugs such as alcohol, heroin or diazepam. This close association with an already high-risk population increases the risk of fatal overdose. The number of pregabalin related deaths have risen sharply in just four years. Pregabalin was mentioned in 54 drug related deaths in 2018, an increase from 5 deaths in 2014.

3.16 Data from the Health and Social Care Board shows that in 2017, 0.28 prescriptions of gabapentinoids were prescribed per head of population in Northern Ireland. This rate was higher than the rate in both England and Scotland, although lower than that of Wales (**Figure 13**).

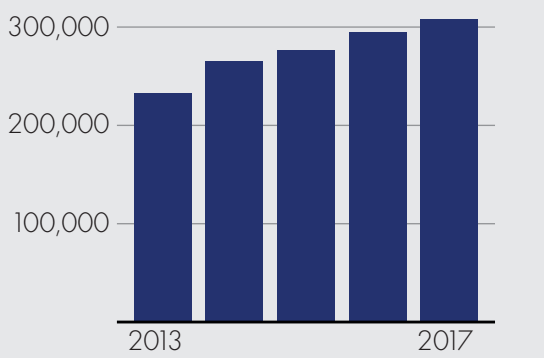
Figure 13. Concerns are increasing about the misuse of pregabalin
In recent years there has been growing concern about the misuse of gabapentinoids and their role in drug related deaths.

Northern Ireland has the second highest rate of gabapentinoid prescription in the UK, but the highest rate of pregabalin prescriptions



Source: HSCB

Despite consistent warnings about the dangers of pregabalin, the number of prescriptions has increased over the last five years



Source: NIAO analysis of BSO data

3.17 Whilst pregabalin and gabapentin have similar therapeutic effects, gabapentin is more slowly absorbed. NHS advice indicates that pregabalin is relatively more dangerous than gabapentin in high doses[16]. Pregabalin appears to be more sought after for misuse than gabapentin.

16 http://www.hscboard.hscni.net/download/PUBLICATIONS/pharmacy_and_medicines_management/correspondence/Opioid-Prescribing.pdf

In Northern Ireland, more pregabalin is prescribed per capita than any other part of the United Kingdom (see **Figure 13**).

3.18 In November 2012, HSCB wrote to all GPs and community pharmacists in Northern Ireland highlighting the potential for misuse of pregabalin and advising "caution should be exercised when prescribing to patients with a history of substance abuse". HSCB issued a further letter in October 2016 highlighting increasing risks associated with pregabalin use, increasing volumes in usage and providing practical steps to be taken in respect of minimising potential misuse of pregabalin. GPs were asked "to be extra vigilant in their initiation, repeat prescribing and review of pregabalin."

3.19 Despite these repeated warnings, prescriptions of pregabalin in Northern Ireland have continued to rise. Just over 230,000 prescriptions for pregabalin were issued in 2013; by 2017 this had increased to more than 300,000 (**Figure 13**). This represents an increase of over 32 per cent.

3.20 As a result of these concerns and as a means of reducing abuse, the Advisory Council on the Misuse of Drugs (ACMD) recommended that pregabalin and gabapentin should be controlled as Class C Drugs under the Misuse of Drugs Act. Following a public consultation, pregabalin and gabapentin were reclassified as Class C controlled substances in April 2019. The change means it is illegal to possess pregabalin and gabapentin without a prescription and it is illegal to supply or sell them to others.

The complexity of care required has changed significantly

3.21 Those seeking treatment for substance misuse are increasingly using more than one drug or type of drug. Polydrug misuse encompasses the use of both illicit drugs and legal substances such as alcohol and medicines. Almost 60 per cent of those presenting for treatment use more than one type of drug, with a quarter of service users reporting use of more than four types of drug[17]. The use of multiple drugs potentially increases the risk of fatal and non-fatal overdose and worsens dependence. Nearly three quarters of drug related deaths in 2018 involved the use of more than one type of drug. The management of polydrug misuse is a complex and challenging task for treatment providers and is often less successful for those who use multiple substances.

3.22 Substance misuse services are also dealing with an ageing cohort of service users, who come with a range of health, social and economic challenges. Almost one third of those presenting for substance misuse treatment in Northern Ireland are over the age of 45[18], and over 85 per cent of alcohol specific deaths in 2017 occurred in this age group. Illnesses such as dementia, diabetes and hypertension, in combination with substance misuse issues, mean that intense and complex care is often required.

17 NI Substance Misuse Database (2016-17). Whilst figures detail the use of multiple drugs, they do not discern if these drugs were consumed in combination.

18 NI Substance Misuse Database (2016-17)

Part Three:
The Changing Nature of Substance Misuse

3.23 It is very common for people to experience problems with their mental health and substance misuse issues at the same time. Evidence suggests that mental health problems are experienced by the majority of drug and alcohol users in community substance misuse treatment[19]. Co-existing mental health and substance misuse issues can make management of treatment more complicated.

Recommendation 2

In planning the forthcoming strategy for alcohol and drugs services, we recommend that the Department includes the complex and long-term care needs of service users. Failing to plan for these needs will result in an increased burden on services, which are already facing significant pressures.

19 Better care for people with co-occurring mental health and alcohol/drug use conditions, Public Health England (June 2017)

Part Four:
Pressures on Substance Misuse Services

Part Four:
Pressures on Substance Misuse Services

Harm reduction services are cost effective

4.1 Substance misuse services are structured in four tiers, in line with NHS guidance (see **Figure 5**). Tier 2 services encompass lower dependency, early intervention and prevention. The Alcohol and Drug Commissioning Framework for Northern Ireland 2013-16 sets out the commissioning priorities for addressing alcohol and drug misuse and provides detail on the role and function of interventions across the four tiers of service delivery. It also describes the evidence base outlining what is effective in addressing alcohol and drug related harm.

4.2 The Commissioning Framework requires that low threshold services should be available for those who misuse alcohol and drugs, but are unwilling or unable to access formal treatment services. Harm reduction interventions such as needle exchange, information on safer injecting and preventing overdose should be locally available.

4.3 Tier 2 services are provided by voluntary and community sector organisations following a competitive tender process, with the exception of the Southern Health and Social Care Trust (Southern Trust), which provides most of its Tier 2 services in-house. There are a number of successful harm reduction and early intervention projects.

Case example 2: Needle and Syringe Exchange

The Needle and Syringe Exchange Scheme provides free, sterile injecting equipment to people who inject drugs. The service also provides disposal facilities for used injecting equipment. This reduces the risk of spreading blood borne viruses such as HIV and hepatitis B and C. It also offers confidential advice and support and helps people to access other support services such as housing or other health and welfare services.

In 2018-19, there were 21 pharmacy-based schemes and 2 Trust-led schemes across Northern Ireland. The PHA funded £197,000 in needle exchange equipment and £103,000 in community pharmacy payments. The number of visits to the service has increased by over 30 per cent in the last five years, to over 30,000 in the 12 months to 31 March 2018. Although there have been challenges in seeking the expansion of the scheme, it is anticipated that further sites will be identified.

Case study 3: Take Home Naloxone

Naloxone is a medication designed to rapidly reverse opioid overdose. The Take Home Naloxone programme was introduced in 2012 and is available to anyone at risk of opiate overdose, through Trust addiction services or the Prison Service. In the first five years of the programme, Naloxone was administered 122 times and was successful in reversing an overdose on 98 occasions. For each successful overdose reversal, £244 was spent on medication. In contrast, an accidental drug overdose typically requires two days in hospital and the average cost of a drug related admission is over £1,000.

Case study 4: Alcohol and You

Launched in October 2013, Alcohol and You was a range of services delivered by the South Eastern Health and Social Care Trust in partnership with a number of voluntary and community organisations to reduce alcohol related harm. The project received £1.26 million of funding, over four years, as part of the Big Lottery Fund's Impact of Alcohol programme. The services available included community based brief intervention clinics provided by ASCERT for adults willing to look at their drinking levels or those affected by someone else's drinking. Up to four sessions were available to:

- Assess alcohol use;
- Build motivation to change;
- Engage in brief interventions; and
- Refer on to other services if required.

Outcomes showed that 95 per cent of service users had reduced their alcohol consumption on exit from the clinics. Alcohol screening test scores reduced from an average of 19.8 (harmful drinking) to 8 (lower levels of hazardous drinking).

Recommendation 3

There is clear evidence that harm reduction projects are a cost effective way of tackling the harms related to alcohol and drug misuse. The Department should ensure the further development of cost effective harm reduction initiatives as part of the new alcohol and drugs strategy.

Links between Tier 2 and Tier 3 services are improving

4.4 The Commissioning Framework requires pathways between Tier 2 and Tier 3 services, however a number of voluntary and community groups told us that statutory services have been hesitant to refer service users to them. They considered that this was partly due to the short-term nature of funding available to voluntary and community groups, meaning that there are lots of "new" projects and people involved in delivery. Some groups also referred to a lack of trust in voluntary and community services amongst the statutory sector. They highlighted the need to build a better understanding of the work done by voluntary and community sector organisations and increase confidence in their services. The Department told us that PHA had developed a framework document jointly with the voluntary and community sector and Tier 3 services to establish links and referral pathways.

Part Four:
Pressures on Substance Misuse Services

4.5 We heard about initiatives to enhance links between Tier 2 and Tier 3 services:

- The Belfast Trust has established an Addiction Hub, providing clinical triage to determine whether Tier 2 or Tier 3 is the correct treatment pathway. Prior to its implementation, the Belfast Trust estimated that one third of referrals to Tier 3 Community Addiction Teams services were more suitable for treatment at Tier 2 community and voluntary services. The aim of the Addiction Hub is to get service users to the right place, early in their treatment journey and to avoid the need to tell their story repeatedly. Feedback from service users has been positive, and the Belfast Trust told us that working relationships with voluntary and community sector colleagues have become closer. This has also reduced pressure, including waiting lists for Community Addiction Teams.
- The Southern Trust is developing a Well Mind Hub to raise awareness of its Tier 2 service with GPs. The intention is to give GPs options and tools to get people to the most appropriate treatment sooner. The Southern Trust also aims to increase the legitimacy of Tier 2 services with primary care providers.
- In the South Eastern Health and Social Care Trust, the Simon Community does outreach work with service users. This work is particularly effective for those not engaging with treatment services or those who may need support to maintain their engagement.

4.6 Whilst some voluntary and community sector providers welcomed these initiatives as positive steps towards collaborative working, they also voiced concerns around a number of issues:

- A continuing lack of awareness of the substance misuse services provided by voluntary and community organisations, particularly amongst GPs;
- Different screening or assessment tools used in Tier 2 and Tier 3 services, leading to inconsistent referrals to services; and
- Increasing waiting lists for Tier 2 services. In one Trust area, waiting lists for some services are around 14 weeks. Whilst the PHA has provided funding to address waiting lists, this is a short term solution.

Recommendation 4

In developing its new alcohol and drugs strategy the Department should explore means of enhancing relationships between the statutory sector and Tier 2 service providers in the community and voluntary sector.

Tier 3 addiction services face a number of pressures

4.7 The HSCB commissions Tier 3 addiction services, which are primarily delivered by the Trusts. Tier 3 services deal with moderate to severe addiction issues and include:

- Specialised drug and alcohol assessment, management and treatment;
- Addiction Day Treatment;
- Substitute Prescribing; and
- Specialist liaison services.

Community Addiction Teams sit within Tier 3 and provide support for GP supervised, home detoxification as well as advice and support for harm reduction and relapse prevention.

4.8 Access to Tier 3 is normally as a result of referral from a GP or other health professional. A number of Community Addiction Teams told us that GPs often refer patients to Tier 3 initially, rather than using Tier 2 services, even when these lower threshold interventions might be more appropriate. A number of reasons were suggested for this, including a lack of awareness of the services provided at Tier 2. GPs have a very short timeframe to make the referral decision and may feel that Tier 3 services are "safer" in terms of governance arrangements and structure, as they are provided by the statutory sector.

4.9 Community Addiction Teams told us of the importance of getting the referral "right first time", as there is a short window of opportunity to get people to engage with services when they are most motivated. In our view, further work is required to ensure that the referral process is efficient and that people can access support quickly. In particular, greater awareness of substance misuse is needed amongst GPs so that people can be referred and signposted to the most appropriate services for their needs.

Recommendation 5

The Department should review the referral process and pathways for access to Tier 3 services, and focus on reducing inappropriate referrals. Raising awareness of addiction services amongst primary care providers should form an important part of this review.

Part Four:
Pressures on Substance Misuse Services

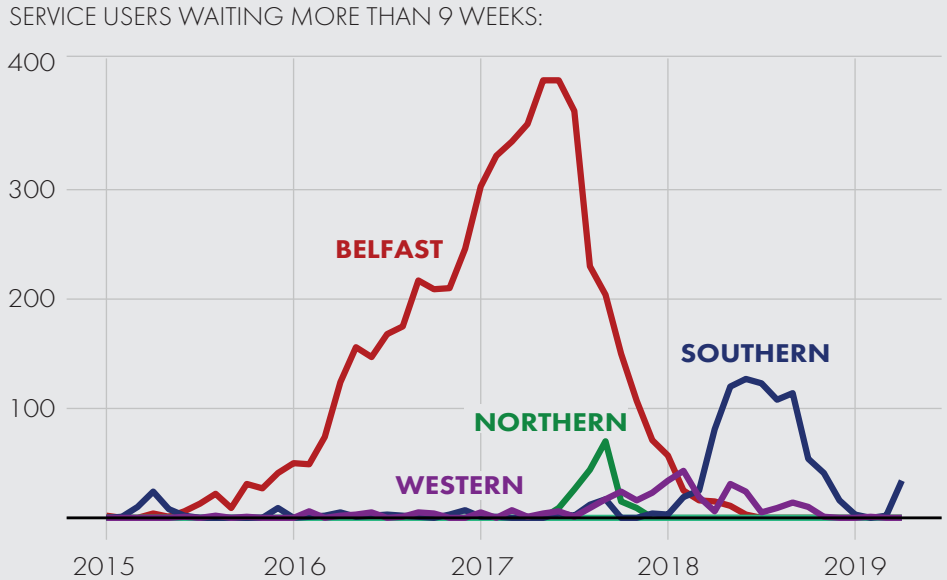
There are often prolonged waiting times for Tier 3 services

4.10 Ministerial targets have been set for the maximum amount of time that people should expect to wait for an appointment with various health services in Northern Ireland. These targets are determined annually within the Health and Social Care Commissioning Plan Direction for Northern Ireland. Mental health waiting time targets apply to addiction services, meaning that no service user should wait more than nine weeks from referral to an initial appointment. A number of Trusts have struggled to meet these targets in recent years (**Figure 14**). During the course of our review, we spoke to Community Addiction Teams from all five Trusts. Without exception, they told us that the number of referrals to addiction services is increasing and that they are struggling to keep pace with the level of demand.

4.11 Whilst an increase in referrals might indicate a positive step, in that more people are seeking treatment, it can lead to significant difficulties in effective service delivery. In July 2019, over 1,100 people were waiting for a first appointment with Tier 3 addiction services across Northern Ireland, although this had been in excess of 1,600 between August and October 2017. During the same period in 2017, around one quarter had been waiting for more than nine weeks for an appointment.

Figure 14. Trusts have struggled to meet waiting time targets for addiction services

The waiting time target is that service users should not wait more than nine weeks from referral for an initial appointment. Whilst there have been recent improvements, Trusts have found it difficult to meet this target.



Over the period under review, the South Eastern Trust consistently met the target.

Source: HSCB

4.12 Northern Ireland waiting time targets for substance misuse services are longer than the targets across the rest of the UK. Furthermore, Northern Ireland is the only region that does not publish separate statistics on waiting times for access to substance misuse services (**Figure 15**).

4.13 Waiting times are important to service users and a high profile measure of how services are responding to demand. Long waiting times can be a deterrent for people seeking treatment, and can contribute to increased dropout rates prior to treatment. Waiting times can also negatively influence health outcomes, prolong risky drug using behaviours and increase the potential for involvement with the criminal justice system.

Figure 15: Northern Ireland waiting time targets are considerably longer than the rest of the UK

	TARGET	OUTCOME
England	**3 weeks** from first being identified as having a treatment need to being offered an appointment to start an intervention	98% offered an appointment within 3 weeks (year ended 31 March 2018)
Wales	Treatment started **within 20 working days** of referral	91.1% (quarter ended 31 December 2018)
Scotland	90% of those referred start treatment within **3 weeks**	93.9% (quarter ended 31 December 2018)
Northern Ireland	**9 weeks** from referral to initial appointment	Not published, however HSCB statistics show 2.9% waiting more than 9 weeks at 31 July 2019

Source: Public Health England; StatsWales; ISD Scotland; and the HSCB.

Since the introduction of substitute prescribing in 2004, there has been a significant increase in demand

4.14 Substitute Prescribing Services (SPS) offer medical treatment for opioid dependency. Opioid Substitution Therapy (OST) involves replacing an opioid, such as heroin, with a longer acting but less euphoric opioid. Commonly used drugs for OST are methadone or buprenorphine which are taken under pharmacists' supervision. Research shows that participation in OST reduces the risk of death by overdose[20], reduces the risk of HIV transmission[21]and reduces participants' involvement in property crime[22]. OST can be used short term or longer term, though long term treatment is likely to produce better outcomes, especially when combined with psychosocial interventions.

20 Mortality prior to, during and after opioid maintenance treatment (OMT): A national prospective cross-registry study', Clausen T, Anchersen K, and Waal H (2008)

21 Interventions to reduce HIV transmission related to injecting drug use in prison, The Lancet Infectious Diseases, Jürgens R, Ball A, and Verster, A (2009)

22 'What caused the recent drop in property crime?' Crime and Justice Bulletin, Moffatt, S., Weatherburn, D., Donnelly, N. (2005)

Part Four:
Pressures on Substance Misuse Services

4.15 Since the introduction of the SPS in 2004, there has been a significant increase in referrals and service users (see **Figure 16**). Substitute prescribing is a long-term harm reduction strategy, and over 43 per cent of current service users have been receiving treatment for over five years.[23] A number of the Community Addiction Teams we spoke to during the course of our audit referred to the significant and ongoing increase in substitute prescribing caseloads, expressing a concern that these are becoming too large to manage safely. One Team Leader told us that there were two key workers[24] managing almost 100 OST service users in their Trust area. In another area, some generic therapists have taken on OST caseloads to ease pressures; however they told us that this is not sustainable and can lead to gaps and pressures elsewhere in the service.

Figure 16: Substitute prescribing has increased by over 50 per cent

	2011	2012	2013	2014	2015	2016	2017	2018
Service users in treatment at 31 March	552	627	648	687	738	778	802	845
Total service users seen in year to 31 March	639	720	755	822	865	922	944	984

Source: Northern Ireland Substitute Prescribing Database Report

4.16 The Belfast Trust in particular experienced a substantial spike in referrals to its Substitute Prescribing Service resulting in significant waiting times for treatment. At the end of 2016, the average waiting time was 47 weeks. By November 2017, waiting times from referral to assessment had reached a high of 57 weeks. The Trust told us that this was caused by increased in demand, staff shortages in the SPS service and recruitment problems, which made it unsafe to induct new patients.

4.17 The Belfast Trust undertook a number of steps to reduce its waiting lists. In addition to the traditional keyworker system, the Trust introduced a clinic model for the review and ongoing management of individuals stabilised on OST. This additional service model has allowed patient flow through the system, creating capacity for intensive one-to-one keyworking at the assessment and early to mid-treatment stages and for ongoing complex patients. Waiting times have reduced as a result of this introduction. In addition, the Belfast Trust has recruited a non-medical prescriber and moved to caseload weighting whereby the non-medical prescriber carries a larger caseload of more stable patients. The Trust continues to work with GPs to move appropriate patients to shared care. The Belfast Trust told us that referrals to SPS have increased by around 300 per cent in the last year, and that demand for the service constantly exceeds its capacity.

23 Substitute Prescribing Database Report (2017-18)

24 A key worker is a specialist addiction worker who is assigned to a service user and works with them to develop a care plan, as well as providing other support including help with access to other medical services and housing support.

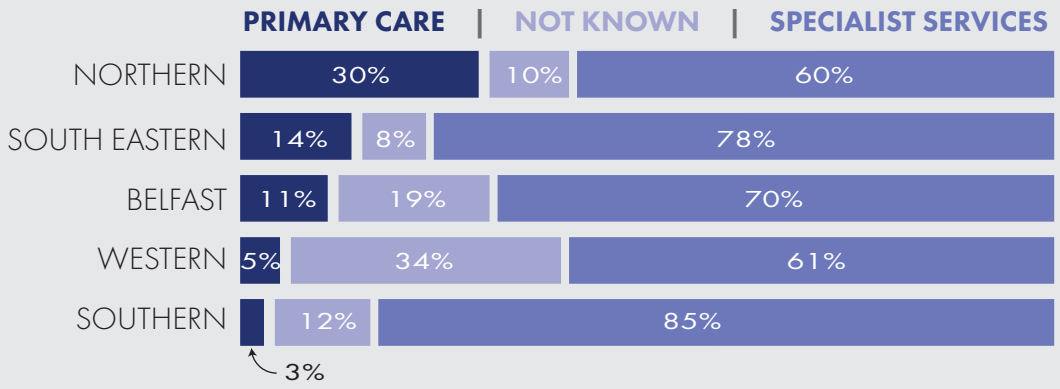
Implementation of a shared care model has not been successful

4.18 Since its inception in 2004, the main principle of the Northern Ireland model for substitute prescribing is that it should operate on the basis of shared care[25]. Shared care encompasses the statutory addiction services, primary care, local pharmacies, voluntary addiction services and any other agencies who may be involved in providing care and support. Under the shared care model, service users who are stabilised should be transferred to GPs for "a significant part of their care and prescribing".

4.19 Community Addiction Teams also told us that delivering SPS in a primary care setting is an important step in normalising treatment for the service user, often much closer to home. However, the vast majority of prescribing responsibility in Northern Ireland remains with specialist services within the Trusts (see **Figure 17**). The Northern Health and Social Care Trust (Northern Trust) has the highest percentage of service users whose prescribing responsibility is shared with GPs at 30 per cent. No other Trust has more than 15 per cent of its service users under the care of their GP.

Figure 17. The majority of prescribing responsibility remains with Trusts

Under the shared care model the expectation is that GPs should be responsible for "a significant part" of providing care and prescriptions for stabilised service users. However, the majority of prescribing responsibility at 31 March 2018 remained with HSC Trust specialist services.



Source: Northern Ireland Substitute Prescribing Database

4.20 The Department told us that it is continuing to work to revise the SPS model, particularly towards a shared care model, supported by specialist addiction services. Whilst we acknowledge that providing a substitute prescribing service is a personal choice for GPs, and that additional training is required, in our view the shared care model presents an important opportunity to

25 http://www.emcdda.europa.eu/attachements.cfm/att_231383_EN_UK27_niguide_substitute_treatment.pdf

Part Four:
Pressures on Substance Misuse Services

transition service users to community based care, and could therefore ease the significant pressure on Community Addiction Teams.

Recommendation 6

The Department should consider the viability of extending the shared care model for substitute prescribing.

4.21 The HSCB and PHA acknowledge that "the increasing complexity of problems, changes in drug using trends and increased levels of referrals to treatment services have led to critical service pressures within Tier 3, including unacceptable delays in accessing treatment". As a result of these pressures they appointed a review team to undertake a "comprehensive review…to guide the future development of Tier 3 service delivery regionally." The review comprises two elements, a focused review of SPS services, followed by a wider review of Tier 3 addiction services.

4.22 The Department told us that a draft report has now been written, and action plan is being prepared. This includes the need for action to increase shared care participation and establishment of a regional project to address the review's recommendations which include variation in practice and greater consistency.

Residential detoxification and stabilisation services have been restructured

4.23 Although most treatment can be safely undertaken within the community Tier 3 setting, a small number of individuals with more complex needs, who are higher risk or more vulnerable, may not respond to community based care. Access to Tier 4 inpatient based addiction treatment is required in these cases. NICE guidelines recommend that inpatient treatment should encompass both initial detoxification and stabilisation (Tier 4a) followed by rehabilitation and support (Tier 4b). Prior to 2014, there were 42 inpatient beds within the Health and Social Care sector, with considerable variation between units. For example, some units operated on a part time basis, some focused upon detoxification while others focused on rehabilitation. Detoxification and stabilisation services were available to residents from the Northern, South Eastern and Southern Trust areas, but there was no access to these services for residents of either the Belfast or Western Trust. Two independent sector organisations provided rehabilitation services in Belfast and Derry/Londonderry.

4.24 The Health and Social Care Board reviewed inpatient based addiction treatment services in 2013 with the aim of reconfiguring services in order to provide a more consistent and regionally agreed service model that could be accessed by all residents of Northern Ireland. The new model encompassed three medically managed detoxification wards (Tier 4a) across three regional sites, managed by the Trusts. Tier 4b services were not considered as part of this review.

Residential care requires more coordination

4.25 Tier 4a has capacity for 500 in-patient stabilisation/detoxification episodes per year. These are provided at Trust sites in Antrim, Omagh and Downpatrick. Access to Tier 4a is by referral from Tier 3 Community Addiction Teams. These Teams told us that the three Tier 4a sites are currently able to cope with the level of demand and that the waiting time for inpatient treatment is around four weeks. The 2013 review recommended that the number of Tier 4a beds should be reviewed by 2019, in light of changing population trends and needs. To date, no further review has been undertaken.

4.26 The review of Tier 4 services considered that more coordination was needed including the "development of a regional coordination role to ensure that inpatient and residential access is managed on patient need and priority". It also recommended the establishment of a Regional Addiction Treatment Network (RATN) encompassing all Trusts and commissioned independent sector providers to oversee and manage Tier 4 arrangements across both sectors. The aim was to ensure that people from all Trusts areas could access Tier 4 care, regardless of where they lived. This regional coordinator role no longer exists, and the RATN has not met for over 18 months.

Recommendation 7

We recommend that a review of Tier 4a detoxification and stabilisation beds is completed to assess whether the number of beds is sufficient. We also recommend that the Department ensures that there is adequate oversight and coordination in place to manage access to beds on a regional basis.

Access to residential rehabilitation is not consistent

4.27 Tier 4b rehabilitation services were not the focus of the original review in 2013. In its review, the HSCB acknowledged there was considerable variation between Trust areas and that a "more consistent and regionally agreed approach is clearly required". The HSCB proposed a number of actions points in respect of Tier 4b services, which included:

- The HSCB would closely monitor demand for rehabilitation care, and working with the independent sector, would increase service provision as required; and
- All Trusts should be able to access Tier 4 rehabilitation care from the existing independent sector providers. Access to these providers would become available, in due course, to all Trust areas.

Part Four:
Pressures on Substance Misuse Services

4.28 Ultimately, the existing service model was retained in Northern Ireland, with capacity for 200 to 300 residential rehabilitation episodes per year, provided by two independent sector providers. Under the existing model, the Southern and South Eastern Trusts do not have formal access to rehabilitation beds, meaning that most patients are treated in the community instead, even when inpatient treatment may be the most suitable approach.

4.29 The Commissioning Framework states that the Tier 4 service model must encompass a number of specific functions, including opioid substitution programmes. However, one rehabilitation provider does not accept residents who are receiving opioid substitution therapy, as it follows an abstinence based model. As a result, referrals to this provider from Tier 3 statutory addiction services are very low, and most residents have referred themselves for treatment. The majority of referrals to the other provider come from the Community Addiction Teams, however it is required to hold a small number of beds for referrals from GPs. This provider told us that it is advocating for the removal of these GP beds, as the unplanned discharge rate for these residents is significantly higher than for those referred by the Community Addiction Teams.

4.30 Aftercare planning is particularly important for those who have undergone detoxification or rehabilitation. Service users are more vulnerable to overdose in the period following discharge if they return to substance misuse. Despite this risk, arrangements for aftercare and support are inconsistent across Tier 4b. One provider offers a two-year programme of support, but this is not part of its contract with the Trusts and it relies on volunteers to deliver this service. Another provider told us that aftercare is the responsibility of the Community Addiction Teams, but that the intensity of support varies between Trusts.

4.31 In our view, residential rehabilitation services are not yet being delivered in a consistent regional way. Inconsistent access criteria, the variety of referral pathways, and a lack of access to beds mean that the service user journey can be fragmented and access to appropriate treatment is often delayed.

Recommendation 8

Regionalisation of Tier 4 has not been extended to residential rehabilitation services. We recommend that a review of Tier 4b is completed to assess the level of demand for rehabilitation care and determine whether the current number of beds is appropriate. The Department should also ensure that all Trusts have formal access to rehabilitation beds, with consistent referral pathways and access criteria across all providers.

Part Five:
Monitoring Services and Treatment Outcomes

Part Five:
Monitoring Services and Treatment Outcomes

The Department's limited performance monitoring means it cannot be sure it is getting value for money or delivering effective services

5.1 Assessing the effectiveness of alcohol and drug treatment is challenging because there is no definitive cure. Treatment often does not take a defined pathway or end point, and people often use services more than once in their lifetime. The Department collects information on substance misuse services through a number of methods. The Substance Misuse Database (SMD) is an annual summary of people presenting to services with problem drug and/or alcohol misuse. In 2016, it replaced the Northern Ireland Drug Misuse Database. Information is requested from treatment services at all tiers, from both the statutory and voluntary and community sectors.

5.2 Information collected from service providers stems from the NSD priorities. Only service users attending for the first time or those who have not attended for treatment in the previous six months are recorded on the SMD. The information collected is largely demographic, for example age, gender and location, as well as details on which substances they are seeking treatment for. The SMD is not outcomes based, service users are recorded once, at the point of entry, and no further information is collected as they continue through treatment.

There are significant issues with data quality and completeness

5.3 Statistics from the first SMD, covering 2016-17, was published in January 2018. However, since then issues with data quality have prevented the Department from publishing any further statistics. The Department told us that there were significant quality issues with the data received from addiction service providers. These included gaps in the information provided by services both from statutory and voluntary and community sector providers and comparable data, which, in the Department's view, was incomplete. The Department told us that such was their concern with the data quality, they were unable to publish it as an official statistic. At the time of our review, the Department was working with the PHA to try to resolve these issues.

5.4 Input into the SMD is voluntary, and the Department has no statutory powers to compel the services it funds to provide information. As a result, returns from service providers can be incomplete, therefore the SMD does not reflect the full extent of substance misuse treatment in Northern Ireland.

5.5 Whilst service providers often have their own information collection systems, these are not necessarily designed to collect the same information as the SMD. Service providers we spoke to highlighted the volume of information and returns required, and the duplication of effort particularly when they have multiple funders to provide information to. This puts an additional burden on already pressurised services.

Recommendation 9

We recommend that the Department engage with service providers and look at best practice elsewhere in the UK to identify the issues that prevent data submission and work to ensure that comprehensive information is collected in future years.

The Impact Measurement Tool has limited coverage of substance misuse services

5.6 The Department also produces the Impact Measurement Tool (IMT) for substance misuse services in Northern Ireland. The IMT assesses the effectiveness of Tier 1 and 2 services funded as part of the NSD and is split into different categories, including Adult Treatment, Young Persons Treatment and Low Threshold Services. Information is collected pre, during, and post intervention and measures the impact of the service on different aspects of lifestyle and behaviours. The main purpose of the IMT is to inform policy makers in the Department and PHA about the impact alcohol and drug services had in the prior year.

5.7 Contribution to the IMT process is a contractual requirement for Tier 1 and 2 service providers, who are predominantly voluntary and community sector organisations. However, Tier 3 and 4 services, which are mainly provided by the Trusts, do not contribute to the IMT. Tier 2 providers that we spoke to questioned the usefulness of the IMT for measuring outcomes. They told us that the information given back to them was nothing that they could not already produce using their pre-existing systems.

5.8 The Department told us that there were a number of limitations with using organisation's own systems instead of regional collection. Whilst not all services collect outcome data, for those that do, information is limited in that it is not collected consistently across services. As such, this could not form a reliable, regional outcome assessment.

5.9 The latest IMT exercise covered the period from April 2016 to March 2017, however it was not finalised until May 2018, 14 months after the period to which it related. The stated purpose of the IMT is to inform policy makers of the impact of treatment services. It is unclear whether the information contained in the IMT remains relevant and useful to decision makers when it is not available until more than a year after service delivery. The Department told us that whilst the annual report is available within a longer timeframe, PHA has access to activity-based information for its commissioned services on a quarterly basis.

5.10 We reviewed the 2016-17 IMT during our audit and noted that for some services, not all service users had engaged for a duration or level suitable for inclusion in the IMT. The IMT is therefore not a comprehensive record of the number of service users seen or treated within each service. As both the SMD and IMT are incomplete, there is no comprehensive record of the

Part Five:
Monitoring Services and Treatment Outcomes

number of service users accessing substance misuse services in Northern Ireland. As a result, there is no way to properly plan services based on demand and the Department is unable to monitor outcomes at a strategic level.

Impacts could not be measured for over a third of service users on the IMT

5.11 Clients are included on the IMT based on their initial assessment by treatment services. We noted that for a number of service types, there was no impact recorded for a significant number of service users. For example, of the 936 service users attending Adult Treatment services, the IMT recorded the impact of treatment as "not measurable" in 513 cases. By contrast, only 10 of the 286 service users attending Parental Substance Misuse had a status of "impact not measurable".

5.12 The Department told us that it is not expected that all clients will stay for one or more reviews. The nature of drug and alcohol treatment with clients is that they might need to be referred elsewhere or disengage completely. An option exists on the IMT spreadsheet for planned or unplanned discharges, where agencies indicate that treatment has finished. In addition to the IMT, the PHA receive other monitoring reports detailing fuller activity and qualitative examples.

5.13 It is concerning that such a high proportion of service users have engaged with services, but the impact of this treatment was not measured. The Department highlighted this issue in the 2016-17 IMT, advising that the significant variation across services warrants further investigation. In total, impact could not be measured for over 37 per cent of service users included in the IMT for 2016-17.

5.14 The recent review of the NSD reported that "data from the Impact Measurement Tool has been assessed as not quite reaching the stringent requirements for publication as an official statistic, which has somewhat limited our ability to see the impact and outcomes these services are having." Given the significant data quality issues with both the SMD and the IMT it is not clear how the Department is assessing the efficiency and effectiveness of substance misuse services using the information it collects.

The Department has little information on the outcomes for service users

5.15 The data that the Department currently collects on substance misuse services is largely activity based, recording the number of service users who enter treatment. However, the Department has little reliable information on the outcomes of treatment for service users.

5.16 In our view, reliable information on outcomes is essential to ensure that the services that are being commissioned in Northern Ireland are effective for service users and providing value for money for taxpayers. Reliable outcome data will be crucial for strategy and planning purposes and as a result it is important that a regionally agreed, consistent approach is established. Whilst we acknowledge that this information can be difficult to collect, ultimately the Department's data should focus on the impact services have on people's lives rather than on how the services themselves are being delivered.

Recommendation 10

The new alcohol and drugs strategy should include clearly defined objectives and outcomes that demonstrate the effectiveness of substance misuse services and ensure that there are mechanisms in place to properly measure these outcomes.

There is no regional information collection on outcomes for Tier 3 and 4 services

5.17 Tier 3 and 4 services are delivered by the Trusts in Northern Ireland. We noted that, while each Trust monitors the clinical outcomes of its addiction services, there is no consistent, regional means of data collection. The Department and the HSCB do not require statutory providers to report directly to them on treatment outcomes. Whilst each Trust does monitor outcomes to an extent, the volume, type and quality of data collected varies and there are no regionally determined outcome protocols. Information on what happens after referral to treatment services is not routinely collected. There is therefore no indication of how many of those referred to services actually continue on into treatment. There is also no monitoring of other outcomes such as employment, family relationships and social outcomes. The only targets that Trusts have in relation to addiction services are the ministerial waiting time targets.

5.18 In contrast, other regions in the UK collect detailed information on substance misuse services which is published in comprehensive substance misuse database reports (see **Figure 18**). Public Health England (PHE) publishes adult substance misuse statistics from its National Drug Treatment Monitoring System (NDTMS). The NDTMS collects data on treatment delivery from over 900 sites, covering every local authority in England. Treatment centres returning data include community-based and specialist outpatient drug and alcohol services, GP surgeries, residential rehab centres and inpatient units.

5.19 Public Health Wales and the Welsh Government publish an annual report on Treatment Data – Substance Misuse in Wales, containing statistics from the Welsh National Database for Substance Misuse (WNDSM). All substance misuse treatment service providers in Wales, in receipt of Welsh Government funding are required to comply with the reporting requirements of the database.

Part Five:
Monitoring Services and Treatment Outcomes

Figure 18: Substance misuse databases in England and Wales contain more comprehensive information[26]

	ENGLAND	WALES	NORTHERN IRELAND
Number of referrals	✓	✓	✓
Demographics	✓	✓	✓
Waiting times	✓	✓	×
Treatment/recovery outcomes	✓	✓	×
Trends over time	✓	×	×

Source: Public Health England; Public Health Wales; and the Department of Health.

5.20 Tier 3 and 4 are the most expensive services to deliver, as service users are likely to have the most complex and severe addiction issues. However, differences in how and what services providers report, and problems with the existing data collection tools make it difficult for the Department and other statutory funders to assess the efficiency and effectiveness of these services. Collecting this information would also allow the Department to understand treatment outcomes for service users and to predict demand for services in order to inform future planning. In our view, it is essential that the Department puts in place a robust monitoring and accountability process for these services.

26 Data collection in Scotland is not on a comparable basis

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