RESPONSE OF THE PRESBYTERIAN CHURCH IN IRELAND TO THE DEPARTMENT OF HEALTH CONSULTATION ON MAKING LIFE BETTER – PREVENTING HARM AND EMPOWERING RECOVERY: A STRATEGIC FRAMEWORK TO TACKLE THE HARM FROM SUBSTANCE USE

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Background

1. The Presbyterian Church in Ireland (PCI) has over 217,000 members belonging to 535 congregations across 19 Presbyteries throughout Ireland, north and south. The Council for Public Affairs is authorised by the General Assembly of the Presbyterian Church in Ireland to speak on behalf of PCI on matters of public policy. The Church's Council for Social Witness seeks to deliver an effective social witness service on behalf of PCI and to the wider community through the provision of residential care, nursing care, respite care and supporting housing for vulnerable people including the elderly, those with disabilities and those transitioning from the criminal justice system. The Council for Social Witness also oversees safeguarding for children and vulnerable adults for the denomination.

2. PCI has an interest in substance use policy as a provider of services and pastoral care to those with addictions, and their families. PCI operates Carlisle House, a residential substance misuse treatment centre, situated near the centre of Belfast, which offers a range of services, advice and information, treatment programmes, and ongoing support services funded by the Health and Social Care Trusts. At Thompson House we operate an approved hostel (PBNI) providing supported accommodation for people in early recovery who were homeless or whose living circumstances were detrimental to their recovery. Additionally, congregations offer a range of pastoral support to individuals and families directly affected by substance misuse.

3. PCI recognises that policy in the area of tackling the harm from substance use requires updating and welcomes this consultation from the Department of Health. The way in which substance use begins, and continues, is changing. Previously alcohol and cannabis were considered to be the 'gateway' drug. However, many people, of all ages, are now beginning their journey with more potent substances, and particularly drugs (both prescribed and non-prescribed).

4. This response is informed by our role as a service provider, the pastoral concerns emerging from our congregations, and the professional expertise and background of our staff within the Council for Social Witness.

Equality/Good Relations and Rural Screening

5. We would suggest that the complexities of substance use and the link between urban and rural areas has not been sufficiently recognised by the screening exercise. For example, in a scenario where new social housing is built in a rural area, a significant number of people with the 'highest' award of social housing points will be offered accommodation there. Housing points are awarded based on the complexity of need, but often those with complex needs who are moved from urban to rural locations find that the support they require does not follow. Significant barriers remain within rural communities, for example limited tiered support options, difficulty in attracting highly skilled staffing, lack of appropriate buildings and travel remains a significant issue.

6. Such discrepancies are recognised elsewhere in the consultation document e.g. at paragraph 2.18 which highlights key messages from last year's NI Audit Office value for money review on addiction services in Northern Ireland. It noted "inconsistencies in the referral pathways for, and provision of, Tier 4 rehabilitation beds across the five Trusts". Anecdotally within the sector it is known for temporary housing providers to 'move' residents to hostels with different postcodes so that the relevant support and treatment can be accessed.

7. Paragraph 3.17 recognises that "there are limitations in using a general population survey to estimate drug use", and that "more chaotic drug users may be under-represented in household surveys". In light of that acknowledgement it is essential that ways are found to identify the true extent of need amongst the most significant cohort of individuals where the highest levels of substance use would be seen.

Vision, Outcomes, Values, Priorities and Target Groups

8. It is important to recognise that many local communities in Northern Ireland remain tied to the legacy of the conflict, with paramilitary control particularly prevalent in areas which will be well-known to those who provide services to at-risk individuals. Building community resilience is key and much work remains to be done. The trauma experienced by communities as a whole needs to be addressed before grassroots support can truly help individuals. Only when this work is done can the person-centred approach be truly effective.

9. The value identified as "Universal, but with an increased focus on those most at risk" is perhaps too general and hard to measure. Further there is a stigma attached in relation to identifying and reaching out to those who suffer from homelessness and are most at risk. Often the services that work with these individuals have limited capacity and so they are referred to lower-tiered support. However, this in turn means that they will not meet the threshold criteria required to access accommodation/housing.

10. The identified priority "supporting people with co-occurring mental health and substance use" is a significant issue. Northern Ireland requires dedicated residential trauma services. Access to such services remains limited when presenting with co-occurring issues, and discussions between professionals often centre on identifying the appropriate pathway e.g. physical disability, mental health or alcohol related brain injury.

11. In regard to target groups and particularly those experiencing homelessness there is a need for gender specific services including accommodation, safe spaces and substance use services.

Outcome A – Fewer people are at risk of harm from the use of alcohol and other drugs

12. With regard to the general indicator identified we would suggest that there are a number of other relevant indicators prior to looking at the % of children in care. These include the following:
    a. Concerns raised by schools
    b. Contact with the PSNI
    c. Contact with Social Services not resulting in Care proceedings
    d. Employer feedback

13. With regard to the indicators relating to alcohol it would be useful to receive some clarification as to how this data will be collected. If it relies on general household data there is a danger that those most at risk will become hidden amongst the more universal indicators. However, data gathered from youth justice, homeless and housing sectors and others has the potential to provide a more nuanced picture and enable better targeting of resources.

14. Another indicator that would demonstrate progress in reducing the number of people at risk of harm from the use of alcohol and other drugs is the number of proactive projects, courses etc. focused on preventative work, and the level of engagement with such projects.

15. In relation to the approach for this outcome we would refer back to the point made above (paragraph 3) that the potential gateway for harmful substance use is increasingly through more potent drugs rather than alcohol or tobacco. While the latter may be the case in a wider population survey, focusing on these entry points has the potential to mask more harmful entry points for higher risk and more vulnerable groups.

16. Of the actions outlined at 6.12 there does not appear to be any new strategies or specific interventions other than A Northern Ireland Prevention Approach. The risk here again is that such a universal approach will not address the needs of the most at-risk groups.

17. Action A7 highlights the Substance Use Liaison role as part of the New Mental Health Service model operating across general hospitals and Emergency Departments. It is vital that there are appropriate and accessible services for the Substance Use Liaison person to which individuals can be referred.

18. Action A11 places a significant emphasis on the role of the Public Health Agency. Will the PHA be encouraged to seek support from third sector agencies and providers, or identify those agencies as the main provider of interventions? Properly resourced partnership working between the statutory and third sectors is an essential delivery component for this framework.

Outcome B: Legislation and the Justice System support preventing and reducing the harm related to substance use

19. The transition from prison is an area which requires significant attention. Prisoners who are released may need support to re-register with a local GP, mental health or addiction service. Many have been discharged with either no, or only a couple of days' prescribed medication, which places the individual at significant risk of accessing and using medication not prescribed to them. There is a lack of consistency in approach and available support. Additionally, there is little addiction support follow and so better links and a joined-up approach between community services and prison services is required. This minimises the impact of work that has been undertaken in prison and ultimately places more pressure on services in the community. This framework provides an opportunity to provide a focus on this much-neglected area.

Outcome C: Reduction in the harm caused by substance use

20. In addition to the indicators relating to drugs at 8.1 we would ask that consideration be given to measuring the impact of harm on someone who presented with a need other than substance use, but who is subsequently exposed to harmful substance. An example of this might be someone who has presented as homeless, moved into a hostel and is then exposed to drug use.

21. Often the view of the general public of those who use substances in a harmful way is that they have 'made a choice' to do so. Wider education is required in order to counter this narrative.

22. Paragraph 8.4 refers to the long-term harms that can be caused by excessive drinking, commonly known as Alcohol-Related Brain Damage (ARBD). In this regard service provision is poor, with only one dedicated ARBD service on the island of Ireland. There is no multi-disciplinary team available to support and treat individuals, and no clear pathway for referrals into appropriate placements. There is also a lack of training and awareness across the Health and Social Care sector. The Department might consider including an action in this framework to begin addressing this imbalance.

23. Action C6 suggests that "a process of strategically reviewing alcohol and drug related deaths at a regional level will be established under the Organised Crime Task Force". To view these deaths through a criminal justice lens seems to be an unnecessarily narrow focus and has the potential to focus solely on the nature of the death rather than the causal factors of addiction. Would this strategic review under the OCTF identify gaps in service provision which may have been a contributing factor, or seek to ascertain other missed opportunities for intervention, help and support?

24. We would suggest that the Overdose and Relapse Prevention Framework, to target those at most risk, highlighted at C7 should include those within the criminal justice system, particularly prison.

25. We've noted that this section does not comprehensively mention dual diagnosis, or the relationship between drug/alcohol use and mental health. While suicide awareness training is mentioned services that specialise in dual diagnosis are desperately needed. Current services need to assess their criteria and ensure that they can support individuals with co-morbidity.

Outcome D – People access high quality treatment and support services to reduce harm and empower recovery

26. The indicators included in this section are reflective of provision within the statutory sector but fail to capture the large numbers of people who receive support from the third sector. Of the indicators that focus on treatment, there is no definition of what constitutes 'treatment'. For example, might this include talking therapy, often provided in voluntary/community sector settings?

27. Paragraph 9.4 refers to the importance of "ensuring a clear pathway to a holistic treatment and support system". Often bureaucracy gets in the way with lack of clarity between trusts regarding the criteria for service provision. It is unclear how these pathways will be cleared.

28. Paragraph 9.7 acknowledges the barriers that women can face in accessing and engaging with treatment and rehabilitation services. However, this is a very brief statement to cover a vast array of specific issues faced by vulnerable women with substance users. Gender specific services are needed to respond to the increasing needs of women presenting with complex drug, alcohol, and mental health issues, often precipitated by trauma.

29. Action D3 identifies the needs for a trauma-informed approach as part of a roll-out of workforce development. Such an approach must be rolled out across all services, with clear points of access and identifiable funding streams.

30. Action D7 must go further than merely ensuring that services are delivered. New services are urgently required that can respond immediately to complex presentations of dual diagnosis.

31. The development of an integrated model between all Tiers of Addiction Services and the Regional Trauma Network is a very pressing matter and vital within the context of the history of Northern Ireland.

Making it Happen – Governance and Structures

32. The focus on cross-border co-operation identified at paragraph 12.5 would be beneficial.

33. Earlier in this document a figure of £900m was quoted as the cost of harmful substance use in Northern Ireland. While recognising that other government departments and agencies also make a financial contribution, the investment of £16m per year by the Department of Health in support of the previous strategy feels like a drop in the ocean in comparison. While it is impossible to disaggregate out costs from overall budgets it would be important to also consider budgets within the criminal justice system, aside from policing, and other initiatives like Supporting People.

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