ARK Policy Brief

Increased Complexity of Clients' Substance Use Needs and Service Provider Responses During and After the COVID-19 Pandemic

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This policy brief draws on published research evidence and discussion at an ARK policy roundtable event on 19th April 2024. The roundtable was conducted under the Chatham House Rule which necessitates anonymous reporting. Attendees included representatives from substance use, mental health and health services in the voluntary, community and statutory sectors, government departments and academia.

Policy and Research Context

In response to the COVID-19 pandemic, multiple infection control measures were introduced in Northern Ireland which constrained mobility and led to temporary closures of education, business and other leisure establishments (NIAO, 2021, 2020). Similar to other jurisdictions, these measures disproportionately affected the most socially marginalised which includes people who use/d drugs. In particular, many people dependent on drugs rely heavily on health and social care services for help and support which were substantially affected by infection control measures (Higgins et al., 2020; Campbell et al., 2021).

The Department of Health (DOH, 2020) issued guidance to help substance use services address the challenges of complying with infection control measures. This sought to ensure services continued to operate and were safe for staff and clients. A COVID-19 Addictions Subgroup was formed to establish regular communication between the DOH, the Health and Social Care Board, the Public Health Agency (PHA) and the five Health and Social Care Trusts (HSCT) (DOH, 2021) and provide information on regional activities needed to respond to COVID-19 outbreaks and how these were to be applied to substance use service providers.

A new substance use strategy was launched in 2021 which promotes an integrated public health-led approach to dealing with substance use (DOH, 2021). It recognises the necessity of inter-departmental collaboration and a joined-up approach to mitigate the multi-faceted reasons for problematic substance use and reduce drug-related harms. It further acknowledges the urgent need for alignment of substance use and mental health services in Northern Ireland. Understanding COVID-19 impacts on drug use trends, related behaviours and service delivery was viewed as important for strategic actions and implementation.

Research commissioned by the Northern Ireland Alcohol and Drug Alliance (NIADA) on the initial impacts of the pandemic upon people who use/d drugs identified adverse health and social impacts (Higgins et al., 2020). A range of impacts were identified including: elevated risk-taking practices due to changes in drug availability; reduced or reconfigured substance use services; and increased use of alcohol, cocaine, and street-sourced prescription medications. During periods of inaccessibility and/or concerns about cost and/or purity and/or financial difficulty, some people who used heroin or cannabis substituted with other drugs. These included street-sourced benzodiazepines, cocaine and synthetic cannabinoids. There was also evidence of more transitions to injecting and more harmful groin injecting behaviours (Rintoul and Campbell, 2021; Campbell et al., 2021; Croxford et al., 2021). COVID-19 public health measures resulted in substantial changes to the delivery of substance use treatment and support services. These either shifted to remote delivery, reconfigured to a compatible format, reduced or were temporarily suspended (DOH, 2021; Higgins et al., 2020).

Policy Roundtable

In 2021, Ulster University was commissioned by NIADA to further explore COVID-19 impacts on clients' substance use, related behaviours and service delivery (Harris et al. 2023). This study provided important additional information on COVID-19 impacts on NIADA clients' who use/d drugs, their families and service providers. The policy roundtable focused on key research findings from this study relating to increased complexity of clients' needs and service provider responses during and after the pandemic and commenced with a presentation by Dr Julie Harris. The PowerPoint is available alongside this publication from the policy brief page of the ARK website. To read the full report of the study, including methodology, see Harris et al. (2023)

Key Findings

Increased Complexity of Needs

The needs of some clients became more complex during the pandemic. The reasons for this were multi-faceted but a major influence was increased levels of deteriorating mental health due to social isolation, anxiety and depression and the temporary suspension and more constrained access to statutory substance use and mental health services. There were frustrations about the lack of dual diagnosis services before and during the pandemic, long waiting lists and inadequate follow-on services after emergency mental health presentations.

Most service providers, family members and two-thirds of clients surveyed reported increased substance use during the pandemic. The reason most cited by surveyed clients was boredom (94%), a factor particularly emphasised for young people, followed by feeling anxious or depressed (92%) and social isolation (81%). Some providers also observed that being furloughed and/or working from home were substantial factors for some clients in the 30-44 years age group. Problematic alcohol and other substance use notably rose in the over 45 years and over 55 years age groups.

Alcohol was the main drug used by clients (76%). All providers observed increased alcohol use, but they also noted increased cocaine, street-sourced benzodiazepine, polydrug use, using alternative drugs or using new drug combinations. For example, people in the homeless community who traditionally used alcohol substituting with synthetic benzodiazepines and pregabalin.

Increased polydrug use and related harms was also important. While this trend was evident pre-pandemic, providers believed that lockdowns had accelerated it. Forty-two per cent of surveyed clients used more than one drug during the pandemic, suggesting a rise in polydrug use and an intensified cohort of clients with complex needs. Increased polydrug use was connected

with multiple factors, including: more availability and use of synthetic benzodiazepines; and some clients' substituting and/or supplementing preferred drugs with other substances. Patterns of polydrug use and related harms within the Belfast Health and Social Care Trust (BHSCT) were replicated more quickly in other HSCT during the pandemic due to changing drug markets, patterns of use and the increased transience of the homeless community.

Some day/drop-in centres and hostel providers reported an initial reduction in overdose rates during the first lockdown. This was related to compliance with infection control measures, reduced movement, resources and drug use. However, overdose rates appeared to rise substantially after the first lockdown period. Other providers reported elevated overdose rates and drug-related deaths throughout the pandemic in community settings. This finding linked to: social isolation; lengthy waiting times to access statutory substance use services; difficulties accessing preferred drugs; trying different substances; increased polydrug use; and higher or inconsistent drug purity levels. For clients in the homeless community, there were also reductions in physical, enclosed spaces for injecting which resulted in more public injecting in remote locations which exacerbated overdose risk.

Increased complexity of needs was also evidenced through raised levels of injecting-related harms for some clients. This change was attributed to a range of issues. These included: clients moving on to injecting at a faster rate; increased injecting frequency related to cocaine (used to supplement or replace other drugs) especially by a younger, less experienced cohort of clients; a reduction and temporary suspension of some statutory substance use services which disrupted existing work with clients and delayed new referrals; more groin injecting and injecting-related injuries; elevated levels of loaning or borrowing injecting equipment; somewhat constrained access to some needle and syringe exchange programmes; and subsequently, more Hepatitis C and Human Immunodeficiency Virus diagnosis. These changes were primarily observed in the BHSCT and South Eastern HSCT. However, providers in other HSCTs noted small increases in injecting cocaine, heroin and related harms.

The changes in drug use and constrained access to statutory services resulted in more demand for NIADA services in the voluntary and community sector, including more clients presenting with complex needs and more emergency presentations.

Service Provider Responses

Findings show that NIADA services responded innovatively to the new and greater challenges by reconfiguring services and developing new and some co-produced services. Remote delivery and service adaptions complied with infection control measures while managing to be responsive to the increased complexity of clients' needs. Service adaptions were also aided through additional funding during the pandemic.

Existing digital inequalities meant that remote service delivery did not work equally well for all clients. Older clients, people in the homeless community, on probation and/or living in rural areas were more likely to be negatively affected by the shift to remote delivery. Some clients also reported being less comfortable with remote delivery than others. Providers were aware that working remotely presented challenges to building rapport, fully assessing clients and risk.

To overcome digital challenges, providers innovatively responded through providing regular phone check-ins with clients and technological devices such as mobiles, tablets and dongles. To help deal with high risk clients, providers continued socially distanced face-to-face services where possible. Low threshold outreach and harm reduction services continued to provide support for people in the homeless community and those dependent on drugs who often lacked

the resources needed to engage with remote services. Services also included providing needle and syringe exchange services, safer injecting advice and ensuring basic needs were met. Priority was given to ensuring these face-to-face services were delivered safely.

Data clearly highlighted that despite increased complexity of client needs, elevated demand for voluntary and community services and major impacts on service delivery, NIADA services responded with innovation and responsiveness to client needs.

Roundtable Discussion

In advance of the roundtable, attendees were invited to consider the following questions:

1. Reflecting on service responses to increased complexity of client needs during the pandemic and since, what worked well and what could be improved?
2. What complex needs are clients currently presenting with? Do these present additional/ new challenges to those identified in the research?
3. How are services currently responding? What is working and what could be improved?
4. Given increased complexity of client needs, what are the implications for workforce development?
5. What are the implications of the research findings for the implementation of the substance use strategy?
6. What are the enablers and barriers to the implementation of the substance use strategy?

Reflections on Service Responses During the Pandemic

The first issue raised by participants was elevated complexity of client needs during the pandemic. Increased partnership and collaborative working between the voluntary, community and statutory substance use sectors was viewed as very beneficial. The point was made that the redeployment of many statutory healthcare workers during the pandemic resulted in increased reliance on cooperation between statutory services and voluntary and community services. There was agreement that the pandemic had demanded a rapid, joined-up approach to deliver services with positive outcomes. However, many collaborative cross-sectoral partnerships established during this period had regressed in the post-pandemic period. Participants strongly emphasised that this issue should be addressed urgently and that given the continued complexity of clients' needs, stronger cooperation rather than siloed working was needed.

Several participants highlighted the positive benefits of remote service delivery methods during the pandemic providing examples of increased service accessibility and engagement while mitigating social isolation for some clients. Their view was that while most services had reverted back to face-to-face, regular phone check-in calls had continued. Some limitations of remote delivery were discussed including the challenges relating to clients in crisis and those with more complex needs, many of whom do not own or use a smartphone. It was believed that continuation of remote services needed to be balanced with considerations of digital poverty.

One participant noted that during the pandemic, there was flexibility around targets for services which provided more opportunity for adaption and responsiveness to emerging client needs. Such flexibilities were no longer in place and a number of people expressed the view that it would be beneficial to have less focus on key performance indicators which, they argued, do not always capture service effectiveness and

support provided. Participants also observed that during the pandemic in all parts of the UK and the Republic of Ireland, rapid service adaption was facilitated through increased financial investment in rapid policy development and implementation. However, the financial freedom to have polices agreed on and supported quickly had ended. In Northern Ireland, this situation was exacerbated by fiscal pressures and reduced public service budgets.

Continued Complexity of Client Needs

There was consensus that increased complexity of clients' substance use and mental health needs had continued post-pandemic and new challenges had emerged. One representative highlighted difficulties in fully understanding current complexity due to the lack of psychosocial analysis and a regional assessment tool.

Discussion also highlighted how some trends and factors influencing increased complexity were evident before the pandemic, including challenges accessing dual diagnosis services. However, it was noted that research is currently being conducted on dual diagnosis provision and work is continuing on creating a managed care pathway. There was strong consensus that drug dependency is complex and often compounded by mental and wider health and structural inequalities, multiple forms of internal and external stigma, homelessness and poverty. Therefore, an adequate response had to include addressing these underpinning factors.

There was agreement that increased polydrug use was evident before the pandemic. However, this trend accelerated during the pandemic and continues to be a source of serious concern exemplified by recent coroners reports on drug-related deaths which cited how six to eight substances were used in some cases. The difficulties treating polypharmacy and multiple drug dependencies was also highlighted as a serious concern.

Attention was given to the importance of changing drug markets within Northern Ireland. All drug types are being brought in and drug distribution networks between Dublin and Northen Ireland have resulted in patterns within Dublin being quickly replicated in Northern Ireland. Increasing prevalence of fentanyl and nitazenes within local drug markets was a major source of concern given greater risk of overdose and death. It was noted that drug testing strips were now available in needle and syringe exchange services to help mitigate harms. While policing organisations wanted to publish timely information on substances and changing drug markets, their ability was limited by delays in drugs testing, coroner's reports and wider resourcing constraints. It was agreed that these issues should be prioritised to mitigate potential harms.

Lack of Standardised Care Pathways and Information Sharing

The lack of clear and standardised care pathways with adequate information sharing between services for complex clients was a concern for participants. The HSCTs use diverse approaches, different biopsychosocial assessment tools and services. The disconnected nature of services and pathways often resulted in multiple assessments and experiences of stigma.

A key point of discussion was the substantial increase in complex clients presenting to emergency services. This had resulted in ambulance services moving into a preventive role and the clinical model with current targets not reflecting the reality of their role. Ambulance services were taking people presenting with problematic substance use and/or mental health issues to emergency departments as the care pathways were unclear. This ambiguity often resulted in prolonged waiting times to access appropriate treatment and support. The service was also unclear about how or when to discharge clients due to unstandardised care pathways.

One participant observed good practice in other regions for complex cases is diverting the person to the appropriate service when they first present. However, in Northern Ireland this process is inhibited by the lack of standardisation, unclear care pathways and varying assessment processes across HSCTs and these issues need to be resolved

The lack of inter-agency information sharing was identified as problematic, particularly with regard to clients with complex needs. There was a call for information about a clients' history to be shared across organisations and departments irrespective of the service or geographical location. This information sharing would help ensure that complex clients' needs are fully addressed.

Workforce Capacity and Training

A number of workforce related issues were identified. The workforce had been negatively affected by staff burnout from COVID-19 and secondary trauma associated with the pandemic and compassion fatigue. The problem of staff retention and recruitment was particularly pronounced for the voluntary and community sector due to greater insecurity, lower salaries and limited employment benefits when compared to HSCT staff and private sector employment. These work environment issues can result in staff feeling undervalued, negatively impacting their work, retention and recruitment. A number of voluntary and community organisations are struggling to retain and recruit new staff and are caught up in a process of continuous recruitment.

Another factor of concern was how statutory substance use services in Northern Ireland often have to deal with the three day follow-up reviews for suicide prevention which is not their role and affects time and resources. It was noted that substance use services in other parts of the UK have clearer direction and their own separate department. By contrast, statutory substance use services in Northern Ireland are managed by mental health which impacts negatively on resources. Subsequently, the need to establish a separate department for substance use services in the region was stressed.

A number of suggestions were made with regard to addressing workforce development needs. These included: cross-sectoral working; regular training and developmental reviews with staff; and for all staff to have specific and ongoing training in substance use and dependency. It was noted that a training needs analysis of substance use services was being conducted which aims to ascertain what staff training is being provided and what is needed.

There was consensus that substance use services across sectors needed to be trauma-informed given increased client complexity. Ensuring that trauma-informed approaches and techniques were integrated into curriculum on the main educational pathways for staff working in substance use service (e.g., nursing, social work and psychology) was emphasised. It was noted that the All Parliamentary Group on Dual Diagnosis and Addiction were currently working on a project related to this issue.

Collaborative, Joined-Up, Health-Led Approach

The benefits of intra- and inter-sectoral collaboration were raised throughout the discussion. It was emphasised that the current strategy aimed to implement a health-led, not a health-owned approach, stressing the importance of working across multiple departments to fully implement the strategy. However, this collaboration can be difficult given competing interpretations of how this should translate into practice, knowledge of substance use, levels of stigma, competing priorities and budgetary constraints.

For example, while the focus of Police Service of Northern Ireland (PSNI) is to disrupt drug circulation and use, the service also has a preventative role. It was suggested that the PSNI could use a text messaging approach to follow-up

with people identified through drug seizures and the dismantling of online or social media market places. However, the PSNI was constrained by funding which affected resources and officer numbers. These issues inhibited increased collaboration with substance use services and expansion of diversionary methods - for example, providing referral and/or signposting to substance use treatment and support services alongside a community resolution.

It was also noted that implementing the current strategy requires politicians, services, departments and the general public to promote and support substance use being addressed as a health issue. However, some representatives noted it was unclear if the general public support a health-led approach as support tends to vary dependent on the context and may be conditional on service provision occurring outside of their own local community and without direct impact on their day-to-day lives. For example, if a needle and syringe exchange service is located within their local community, public support for this initiative varies. It was believed that research ascertaining public attitudes towards drug use and levels of public support for a health-led approach would be beneficial.

The value of cross-jurisdictional learning was discussed. While there is some overlap between reserved and devolved powers in the UK, it was noted that approaches being adopted by the Scottish government (e.g., overdose prevention centre and drug checking services) pointed to the Home Office operating a more hands-off approach allowing scope to develop local responses to drug-related harms.

Financial Investment

There was strong support for greater investment to support the implementation of the substance use strategy and address urgent resourcing across services. These included financing: the recovery pathway; prevention and early intervention; tackling stigma; dual diagnosis services; rapid drug testing; and police diversionary methods. Investment in anti-poverty measures and housing is also needed.

The insecurity and adequacy of funding for the voluntary and community sector is a major challenge, with strong competition for PHA funding. Commissioning models and practice means that smaller local services compete with organisations from other parts of the UK and larger organisations. While the procurement advantage held by smaller local organisations is the connection to the locality, this is not always sufficient to ensure they get a contract. The importance of social value in applications was also discussed. A challenge for smaller organisations is that social value must be delivered at no cost to the commissioner. It was advised that community and voluntary sector services seek advice and guidance on social value (in particular from the Strategic Investment Board). The PHA's inclusion of people with lived and living experience in the commissioning process was noted as a positive development.

Key Points and Recommendations

The underpinning research and roundtable discussion point to significant challenges. Some of these emerged during the pandemic and have continued. In other cases, the pandemic exposed existing trends and problems. The substance use strategy provides a basis for progressing but has been limited by budgetary constraints and other factors. However, without action across a number of policy and practice areas, there will be a deepening crisis.

It is evident that the response to the COVID-19 pandemic included increased and improved inter-agency collaboration. While this has been difficult to maintain post-pandemic, it is vital to ensure effective and efficient responses. However, it is difficult for collaboration to flourish within a context of inadequate funding. For example, knowledge of drug markets and drug use is vital to the development of policy and practice responses, but this is inhibited by delays in drug testing, coroners' reports and limitations of PSNI budgets.

It is also clear that client complexity continued post-pandemic due to multiple factors, some of which existed pre-pandemic. Of particular note is structural and health inequalities, polydrug use, changing drug markets and increasing prevalence of strong synthetic opioids. Internal and external stigma continues to be a major deterrent to people who use/d drugs and their families seeking help. Stigma around substance use can also limit policy makers and service providers responses. We know little about the Northern Ireland public's attitudes towards drug use and services, bar ad hoc media reports. These issues present substantial challenges for services across departments.

A number of issues with current service provisions were identified. The diverse and inconsistent approaches to assessment, services and care pathways across the HSCTs was identified as problematic. There was support for a regional assessment tool and more information sharing across sectors, services and departments to ensure complex clients' needs are met. It was noted that work was ongoing on a managed care pathway for dual diagnosis and this was welcomed. There were also clear workforce capacity, training and development needs highlighted across services. Particular emphasis was placed on the need for trauma-informed approaches, regular staff training and addressing staff recruitment, retention and resourcing.

Government departments and statutory bodies in Northern Ireland have experienced budgetary cuts and work within the limitations of one year budgets. Funding for many voluntary and community organisations is consistently insecure, affecting their ability to recruit and retain workers, respond to clients' complex needs and demand for services. This leaves limited capacity to work on collaborative networks, test out new models and input into policy discussions.

On the basis of the roundtable discussions, the following recommendations are proposed.

1. There was strong agreement, supported by research, that greater financial investment is needed in cross-sectoral substance use services and other departments to tackle workforce capacity and training and implement the substance use strategy. A failure to invest does not make fiscal sense given the increased future cost to health and other services. This investment should be accompanied by a review of funding and commissioning structures to ensure that voluntary and community organisations (especially smaller organisations) are not disadvantaged.

2. The response to the pandemic demonstrated that organisations have the ability to be responsive and innovative which was partly facilitated by the relaxation of some performance targets. While it is important to measure and evaluate performance, it is widely accepted that inappropriate or inflexible targets can inhibit developing appropriate responses, especially in complex and rapidly changing environments. There should be a review of targets to assess continuing validity with examination of the opportunity to build in some flexibility.

3. The lack of standardised care pathways across HSCTs and adequate information sharing and collaboration is concerning. There should be a review of existing care pathways accompanied by the development and implementation of a regional assessment tool, one-point of referral for all clients accompanied by adequate information-sharing and collaboration across sectors and departments where possible.

4. Stigma continues to be a major barrier to treatment and support for people who use/d drugs and their families. More robust knowledge based on research examining levels of stigma among the general public, health and social care providers and experiences of stigma among people who use/d drugs and their families would help inform future policy and practice.

5. There is currently a workforce crisis in the voluntary and community sector, mirroring the more widespread crisis across health and social care. This needs to be addressed through monetary recognition of the value of this work and opportunity for qualifications and progression built into a workforce development strategy.

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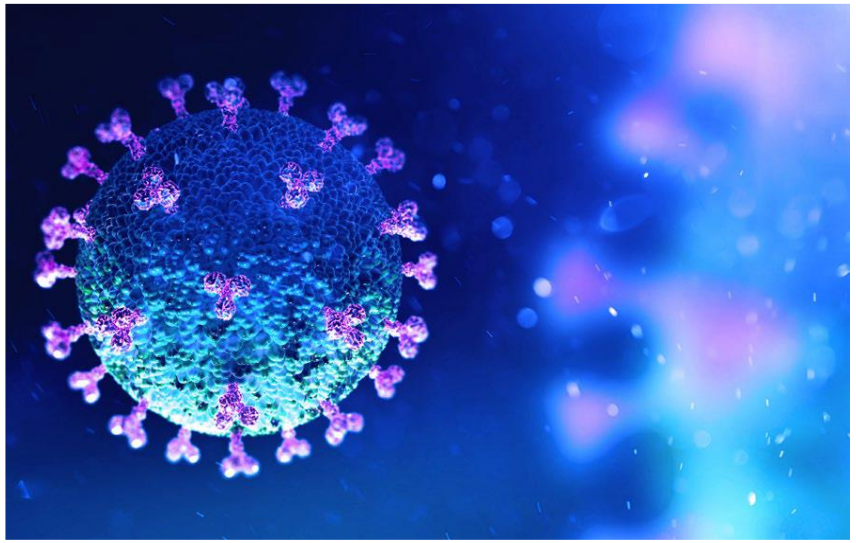

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Overview

- Study Design
- Results:
  - Increased complexity of client needs
  - Service provider responses
  - Going forward
- Policy roundtable discussion

Sequential Mixed Methods Design

(May to Nov 2021)

Phase 1

- Staff journal entries (n=56)
- Service provider survey (n=10)
- Service provider focus groups (n=8) and semi-structured interviews (n=2)
  - 10 senior NIADA representatives covering all HSC areas in NI.
- Family members focus group (n=2) and semi-structured interview (n=1)

Phase 2

- NIADA client survey (n=98)
- Client semi-structured interviews (n=11)

Data Analysis

- Descriptive and inferential testing of quantitative data
- Qualitative data thematically analysed

Increased Complexity of Client Needs

Mental Health Deterioration:

- Increased anxiety and depression.
- Difficulty dealing with social isolation.
- Constrained access to statutory mental health services:
  - Pre-pandemic issue but increased inaccessibility during pandemic.
- Lack of dual diagnosis services.

Increased Substance Use:

- Continued drug accessibility and availability.
- Boredom.
- Social isolation.
- Constrained access to statutory services.

Increased Complexity of Client Needs

Increased Polydrug Use:

- More availability and use of street-sourced benzodiazepines and pregabalin.
- Substituting or supplementing preferred drugs.
- Patterns being replicated quicker outside of Belfast.

Increased Overdoses and Drug-Related Deaths:

- Increased following first lockdown but some community-based organisations experienced elevated rates throughout the pandemic.

Multiple factors including:

- Social isolation; long waiting times to access statutory treatment services; using different substances; increased polydrug use; higher or inconsistent purity levels; increased levels of public injecting; and some younger clients becoming less risk adverse.

Increased Complexity of Client Needs

Increased Injecting-Related Harms:

- Predominantly confined to BHSCT and SEHSCT.
- Increased cocaine injection among a young, inexperienced cohort.
- High-risk injecting practices.
- Decreased motivation to engage with harm reduction.
- Displacement.
- Increased HCV and HIV rates.
- Constrained access to statutory substance use services.

Service Provider Responses

Rapid transition to remote delivery and other programme adaptions:

- Increased demand for services.
- Remained responsive to increasingly complex clients.
- Increased funding.

Challenges:

- Digital inequalities
  - Older people; rural areas; homeless community; people on probation.
- Limitations of Remote Delivery
  - Confidentiality and anonymity.
  - Building relationships and rapport.
  - Fully assessing clients and risk.
  - Preference for communicating face-to-face.

Service Provider Responses

Overcoming Challenges:

- Continued provision of socially distanced face-to-face services:
  - E.g., ‘Walk and Talk’; people in crisis; outreach and harm reduction services; shortened in-patient residential rehabilitation programme operating at reduced capacity.
- Developing new, innovative and co-produced services.
- Increased funding and support.
- Cooperation between service providers.

Going Forward

- Need for continued and improved cooperation and coordination between sectors.
- Adopting a blended, hybrid model based on client needs and preferences.
- Tackling stigma:
  - Public awareness and education campaigns.
  - Adopting person-centred, trauma-informed, strength-based approach.

Continued investment and development of services:

- Political and organisational investment.
- Tackling poverty.
- Develop and expand programmes and ensure meaningful involvement of people with lived experience:
  - Dual diagnosis; harm reduction services; OST and Tier 4 services; aftercare services.
- Investment in ongoing research and evaluation.

Policy Roundtable

Discussion Points:

1. Reflecting on service responses to increased complexity of client needs during the pandemic and since, what worked well and what could be improved?
2. What complex needs are clients currently presenting with? Do these present additional/new challenges to those identified in the research?
3. How are services currently responding? What is working and what could be improved?
4. Given increased complexity of client needs, what are the implications for workforce development?
5. What are the implications of the research findings for the implementation of the substance use strategy?
6. What are the enablers and barriers to the implementation of the substance use strategy?