The Regulation and Quality Improvement Authority

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An Independent Review of Risk Assessment and Management in Addiction Services

June 2015

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reports are submitted to the Minister for Health, Social Services and Public Safety and are available on the RQIA's website at www.rqia.org.uk.

Acknowledgement

The findings of this review along, with the feedback from service users, will contribute to overall improvements in risk management of addiction services in Northern Ireland.

The review team thanks HSC trust staff for their support and facilitation of this review.

RQIA has made **15** recommendations for improvement.

Reviewers also extend their appreciation to the service users who volunteered their time and who contributed their views to the review team.

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1.0 Executive Summary

As part of its 2012-15 review programme, RQIA planned to conduct a review of risk management processes in addiction services, with the aim of providing an indication of how successful the implementation of the DHSSPS Promoting Quality Care (PQC)[1] guidance has been by trusts.

At the time of the review, the PQC guidance was being reviewed by DHSSPS and a consultation process was also being undertaken by the Health and Social Care Board in relation to proposed changes to inpatient based addiction services. RQIA limited its review to an audit of 100 files in addiction services - 20 from each trust, in order to examine the process of risk assessment and risk management. Four inpatient addiction wards were also inspected by the RQIA mental health and learning disability team during this review. Findings from these inspections are available separately on the RQIA website.

Focus group discussions were facilitated by each HSC trust which provided access to 35 service users. A number of service users outlined extremely positive experiences of their interaction with addictions services. Others suggested that many barriers still exist in being able to get the appropriate treatment and support at the right time. Service users said that when they did go to their doctor to get help, this presented them with a window of opportunity, as they were in the right frame of mind to benefit most from treatment. A prolonged delay could result in them being in a more vulnerable position, running the risk of a further relapse.

Records of service users examined by the review team indicated that 50 per cent of service users with addiction problems demonstrated a significant history of mental health problems. Some service users considered that general medical practitioners (GPs) were not experienced enough to know what to do for service users with addictions. Only a small minority of service users who abused drugs stated they were given information about self-help groups in their area. Significant variation was noted within referrals made by GPs to addiction services, in terms of content, amount of information provided to inform a risk assessment and of the detail of the intervention(s) implemented by the GP. Reviewers also found very little evidence of the use by GPs of alcohol or drug screening tools.

Reviewers found very little evidence within service users notes of them being offered evidence-based written information about their condition, or about the treatment and care they should be offered, or about the service providing their treatment and care. The National Institute for Care and Excellence (NICE) Guidelines recommends that service users should be offered clear written information and advice on aspects of lifestyle that require particular attention during opioid detoxification such as a balanced lifestyle, adequate hydration, information about sleep and physical exercise.

[1] Promoting Quality Care (PQC) DHSSPS Guidelines 2010

Brief risk screening tools, recommended by PQC, were being used by HSC trusts during the initial assessment of the patient following their referral to addiction services. However, only 31 per cent were completed accurately, with significant sections being left blank. There was limited of the use of recommended psychological interventions, such as cognitive behavioural therapy (CBT), which is an evidence based therapy for alcohol dependency.

A significant number of assessments were not signed by service users, contrary to PQC guidance. The frequency of review of service users' risk assessments also varied between trusts. These were not always carried out at regular intervals in line with PQC guidance. The absence of regular reviews of a patient's risk assessment is concerning, as changes in service users' circumstances could be missed, resulting in potential harm to the patient or others.

Limited evidence of interagency working with service users with an addiction and mental health diagnosis was noted. No evidence was present in over 50 per cent of the patient records sampled of any contingency plan to support the patient, in the management of their assessed risk. A consistent theme from service users was the need for appropriate supports following discharge from addiction services.

A high proportion of service users were discharged from addiction services for non-attendance, typically after missing two appointments, or not engaging with the service at all. These patents often fall between services and are therefore at greater risk. Reviewers were not always able to identify who followed up these service users, or whether the GP or mental health services had been appropriately informed about their disengagement. GPs and other relevant staff need to be kept informed of service users who have been discharged due to non-attendance. Given the 30 per cent increase in clients being referred to addiction services in the past two years, engagement with service users is vital, as they know what works for them and what is important on their journey to recovery.

Innovative programmes were evidenced by the review team, including the Break Thru programme of psychoeducation, the Group Education and Motivation Support (GEMS) delivered in partnership with the community addiction team in the Southern Health and Social Care Trust, and the Changing Together and Keeping It Going groups in the Northern Health and Social Care Trust.

The review team's overall findings indicate that the DHSSPS PQC guidance was not being fully utilised to inform decisions for service users, particularly in relation to risk assessment and subsequent management of risk.

The review team has made **15** recommendations in order that the relevant bodies involved in risk assessment and risk management in addiction services can make further improvements in the provision of their services.

2.0 Background to Terms of Reference

This review was designed to carry out a detailed examination of risk processes throughout addiction services, in order to assess compliance with PQC guidance. However, when initial scoping work was begun two pieces of information emerged.

1) In line with the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) Alcohol and Drug Commissioning Framework for Northern Ireland (2013-2016)[2] a reconfiguration of trust addiction services was agreed to be carried out.

2) In line with a recommendation contained in the previous RQIA review of PQC implementation by trusts, the DHSSPS was undertaking a review of PQC guidance.

In light of these facts, it was decided to amend the RQIA plan for a detailed review of addiction services. A revised plan was agreed with DHSSPS to carry out a review of risk assessment and risk management in addiction services. This involved an examination of 100 patient files in each trust, assessing them against PQC. Tools were also used to assess alcohol and drug misuse based on the National Institute for Health and Care Excellence (NICE) [3]guidance.

An inspection of the four inpatient addiction wards in Northern Ireland was carried out by the RQIA mental health and learning disability team in April 2014. This was part of the planned activity of inspections. A separate inspection report of the findings of these inspections can be found on the RQIA website.

2.1 Terms of Reference

1. To undertake an audit of 100 patient files (20 from each trust), focusing on the care pathways in relation to how risk is being managed between primary care, secondary care and Community Addiction Services.

2. To undertake focus group discussions with service users in each trust and obtain their personal experiences of using addiction services in Northern Ireland. Participants within each group consisted of both males and females who had experience of alcohol and/or drug misuse. This included misuse of opiates, either orally or via injection, prescription drugs, stimulants and solvents.

3. To report on findings, make recommendations for improvement and publish a review report.

[2] http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_phase_2__2011-2016_
[3] NICE Clinical Guideline 52: Drug Misuse: Opioid detoxification. NICE Clinical Guideline 115: Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence

2.2 Membership of the Review Team

Mrs Theresa Nixon	Director of Mental Health, Learning Disability and Social Work, RQIA
Professor Nichola Rooney	Clinical Psychology Professional Advisor Mental Health and Learning Disability, RQIA
Mr Alan Guthrie	Inspector for Mental Health and Learning Disability, RQIA
Dr Mary McClean	Project Manager, RQIA
Mr Gareth King	Graduate Intern
Miss Patricia Corrigan	Administrative support, RQIA

3.0 Methodology

1. An audit of 100 files in community addiction services was carried out between 7 and 11 April 2014, with 20 files being reviewed in each trust. The files selected related to service users with alcohol dependency and/or drug misuse, who had been discharged from community addiction services. Some service users had received both treatment from community addiction services and inpatient treatment.

The review team examined the following specific areas:-

- Patient referral routes into the service and the quality of referral information provided.
- Use of the PQC brief risk assessment tool and, where relevant, the comprehensive risk assessment tool.
- Assessment and interventions used for alcohol dependency and drug misuse based on NICE guidelines[4].
- Discharge summary and follow up information provided to GPs by trusts.

2. An assessment of treatment and management was also carried out to assess whether appropriate interventions such as cognitive behaviour therapies, behavioural therapies or social network and environment based therapies were being offered to service users.

3. The four inpatient addiction services were also inspected during the period of the review by the RQIA mental health and learning disability team. The inspection reports from these services can be found on the RQIA website[5].

4. A series of focus groups were arranged in each trust to obtain the views and experiences of service users regarding addiction services.

[4] NICE Clinical Guideline 52: Drug Misuse: Opioid detoxification. NICE Clinical Guideline 115: Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence
[5] http://www.rqia.org.uk/what_we_do/mental_health_and_learning_disability/inspection_reports_2013_2014.cfm

4.0 Introduction and Background

4.1 Context

Alcohol and drug misuse and associated harm cost Northern Ireland hundreds of millions of pounds per year. However, the monetary cost can never fully reflect the impact that substance misuse has on individuals, including children, young people and other family members.

The DHSSPS published guidance in 2010 on the assessment and management of risk in mental health and learning disability services – Promoting Quality Care (PQC)[6]. The guidance described the principles of best practice with regard to working with service users and carers, team working, risk management processes, communication, recovery and positive risk taking. In October 2012 RQIA published a report of its review, which examined the implementation of PQC in HSC trusts[7]. The review noted that PQC guidance seemed to be well embedded in trust processes however, there were a number of areas that required improvement and a number of recommendations were made which included:

- DHSSPS should review the PQC guidance, due to the lack of its implementation in many ways, by trusts, to provide prompt access to information by all professionals.
- Electronic versions of risk assessment forms should be prioritised.
- Trusts should emphasise that risk assessment should be integrated into a wider assessment and not be considered an additional task.
- The requirement for a comprehensive risk assessment should be determined following an initial risk screening of individual circumstances.
- All staff should use the most up to date risk assessment tools.

The review noted that a number of trusts were not using validated risk assessment tools to assess addictions and that there were significant gaps in training in assessment and management of risk.

In 2010, a Department of Health Social Services and Public Safety (DHSSPS) publication estimated the cost of alcohol abuse in Northern Ireland could be as much as £900 million per year. The annual cost of alcohol misuse to the HSC sector alone is estimated to be around £250 million and increasing by 9 per cent year on year.[8]

[6] Promoting Quality Care. Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services. September 2009. DHSSPS.
[7] Review of the implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services. Overview Report. October 2012. RQIA.
[8] Department of Health, Social Services and Public Safety (2014) New Strategic Direction for Alcohol and Drugs, Phase 2, Second Update Report (June 2014)

In December 2013 RQIA published a report entitled Access to Evidence based Psychological Therapies for Adults who Subsequently Complete Suicide[9]. A review of 40 patient files was carried out which set out a number of findings including:

- Service users were often passed across teams where there is a joint history of alcohol and drug misuse.
- Service users presenting with a history of self-harm and suicide attempts had been referred from community mental health teams to community addiction services, with no evidence of follow up from mental health services.
- Service users frequently did not engage with community addiction services and were often discharged without being seen, resulting in difficulty in the further management of these cases.
- There was little evidence of access to psychological therapies.
- The varied type of risk assessments used to identify risk, as a means of reducing harm to the service user.

To gain further assurance in the areas of risk assessment and risk management, RQIA included in its 2012-2015 programme a review of risk assessment in addiction services.

4.2 Risk Assessment and Management Processes

PQC guidance outlines that there are two components in relation to the management of risk. The first is risk assessment, which seeks to identify the specific risks in an individual; and the second, risk management. The risk assessment plan should include the identification of who is responsible for implementing the risk management plan; the reporting and monitoring mechanisms that will be used to assist the service user and the individual responsibilities of any other member(s) of the multidisciplinary team. This sets out the plan of treatment and support(s) available for the service user.

It is good practice that every individual referred to secondary mental health services should receive an initial screening for risk as part of their routine mental health assessment.

In response to the risk factors identified with the service user, by use of the risk screening tool, a clinical decision may be taken to progress to a comprehensive risk assessment. This should be considered on an individual basis and carried out as a multidisciplinary process.

The care plan will then outline the process of how risk is to be managed and should provide details of the full range of support services required for each individual. The service user, the risk assessment and management plan should be reviewed on a regular basis appropriate to the individual. This should be updated in accordance to any change in relation to identified risk.

[9] Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide. RQIA 2013.

4.3 Profile of Drug and Alcohol Use in Northern Ireland

The number of people in treatment in Northern Ireland increased from 5,916 at 1 March 2012 to 8,553 at 1 September 2014 (an increase of 45 per cent). Some of this difference can be explained by a higher number of organisations contributing to the Census (70 in 2012; 93 in 2014). However, a direct comparison of the 63 organisations that contributed to both the 2012 and 2014 censuses showed a 30 per cent increase in clients between the two years[10].

Of those in treatment for alcohol and/or drugs:

- Almost three-fifths (57 per cent) were males aged 18 and over, a third (33 per cent) were female aged 18 or more and a tenth were aged under 18 (6 per cent male; 4 per cent female).
- Almost half (45 per cent) were in treatment for alcohol only, while a third were in treatment for drugs only and a quarter (24 per cent) were in treatment for both drugs and alcohol.
- Drug misuse in Northern Ireland in terms of numbers of people affected is much lower than alcohol abuse. It is also a key public health priority due to its overall impact on society.
- Over a quarter of people (28 per cent) were receiving treatment in the Belfast Trust area, with 23 per cent in the Southern Trust, 18 per cent in the South Eastern Trust, 15 per cent in the Western Trust and 10 per cent in the Northern Trust.
- Over half of people (54 per cent) received treatment through non-statutory organisations, with 42 per cent receiving treatment through statutory organisations.
- The majority (93 per cent) of those aged under 18 received treatment through non-statutory organisations.
- The majority of people (95 per cent) were being treated in a non-residential setting.

In 2013, the DHSSPS Annual Report on progress against Northern Ireland's New Strategic Direction for Alcohol and Drugs Phase 2 stated that 400 people die each year from alcohol and/or drug related causes. Drug related mortality has increased from 2003 at 62 per cent deaths to 68 per cent in 2013.[11]

4.4 Current Model of Service Provision in Northern Ireland

The provision of mental health services in Northern Ireland is based on the regional care pathway which provides a five steps model of intervention. [12] This care pathway is implemented to support people who experience mental ill health and for their families and friends. The term mental ill health covers a broad spectrum of mental health problems including Depression, Anxiety and

[10] http://www.dhsspsni.gov.uk/drug-alcohol-census-2014.pdf
[11] The Northern Ireland Statistics & Research Agency (NISRA) Annual Report of the Register General (2013)
[12] http://www.hscboard.hscni.net/mentalhealth/Regional_Care_Pathway_Mental_Health.pdf

Panic disorders, Post Traumatic Stress Disorders, Obsessive Compulsive Disorder, Addictions, Eating Disorders, Schizophrenia, Bipolar and Personality Disorders. The care pathway sets out the practice expected to be provided by all mental health and psychological therapy services provided by Health and Social Care Trusts, including those services commissioned from independent community and voluntary sectors organisations.

Stepped Care Model of Provision - how services are organised

Step 1 Self-directed help and health and wellbeing services.
Support at this level usually involves responding to stress and mild emotional difficulties which can be resolved through making recovery focused lifestyle adjustments and adopting new problem solving and coping strategies.

Step 2 Primary Care Talking Therapies.
Support at this level usually involves responding to mental health and emotional difficulties such as anxiety and depression. Recovery focused support involves a combination of talking therapies and lifestyle advice.

Step 3 Specialist Community Mental Health Services.
Support at this level usually involves responding to mental health problems which are adversely affecting the quality of personal / daily and/ or family/ occupational life. Recovery focused support and treatment will involve a combination of psychological therapies and/ or drug therapies.

Step 4 Highly Specialist Condition Specific Mental Health Services.
Support at this level usually involves providing care in response to complex/ specific mental health needs. Care at this step involves the delivery of specialist programmes of recovery focused support and treatment delivered by a range of mental health specialists.

Step 5 High Intensity Mental Health Services.
Support at this level is usually provided in response to mental health needs, including adopting new problem solving coping strategies, which involves the delivery of intensive recovery focused support and treatment provided at hospital.

4.5 Referral into Trust Addiction Services

Referrals into addiction services are accepted from a number of sources:

- Self-referral for service users already known to services; but currently, new service users cannot directly access specialist addiction services without going through their GP.
- GPs.
- Inpatient general hospital services.
- Substance misuse liaison nurses located in hospital emergency departments (EDs).
- Voluntary sector.
- Drug Arrest Referral Teams (DART) in partnership with the Police Service of Northern Ireland (PSNI).
- Other statutory organisations such as the Criminal Justice System.

Access route(s) into addiction services vary across trusts. The Belfast and Southern Trusts operate a one point of referral (OPR) system, which is the gateway for all emergency, urgent and routine referrals for mental health assessment, including addictions referrals. All patient referrals are triaged and directed to the relevant service, according to the nature of the patient's assessed needs. All trusts, with the exception of the Belfast Health and Social Care Trust (BHSCT), accept direct referrals from GP practices into their addiction services. However, the BHSCT is giving consideration to accepting referrals directly from GPs in the future.

The Southern Health and Social Care Trust (SHSCT) does not have a DART service and service users who are not known to the addiction service, in common with the South Eastern Health and Social Care Trust (SEHSCT), Western Health and Social Care Trust (WHSCT) and BHSCT, cannot self-refer. In the Northern Health and Social Care Trust (NHSCT), one clinic accepts all self-referrals from those previously known to the service and another accepts self -referrals from service users who have a planned discharge from the service, within a three month timeframe.

There is an obligation on the referrer to supply enough information to make an initial assessment regarding the urgency of the referral. Referrers such as GPs or other primary care professionals have an obligation to provide sufficient information to inform the risk assessment process. An urgent categorisation requires that a service user is seen within two weeks and routine referrals must be seen within nine weeks. If the clinical information does not support an urgent categorisation, or is not comprehensive enough in detail, the referral agent may be contacted and the patient's referral may be re-categorised as a routine referral.

5.0 Key Findings from the Review

5.1 Quality and Content of Patient Referrals

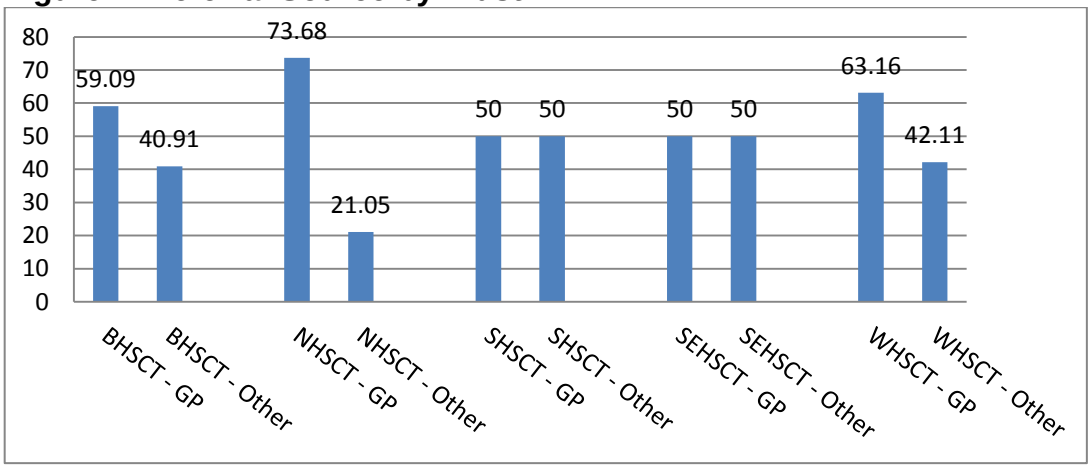
Quality and content of referral information contained in patient files, including use of assessment tools and interventions offered to service users at step two (primary care intervention) were assessed by the review team.

Step two of the model of service provision consists of provision of alcohol/drug related information and advice, triage assessment, referral to more structured treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange and aftercare).

5.1.1 Source of Referral

Of the 100 files reviewed, 59 per cent of referrals were made by GPs. The remaining referrals were from Drug Arrest Referral Teams, substance misuse liaison nurses and other mental health professionals. Figure 1 illustrates the breakdown of referral sources by trust.

Figure 1: Referral Source by Trust



5.1.2 Contact Details and Reason for Referral

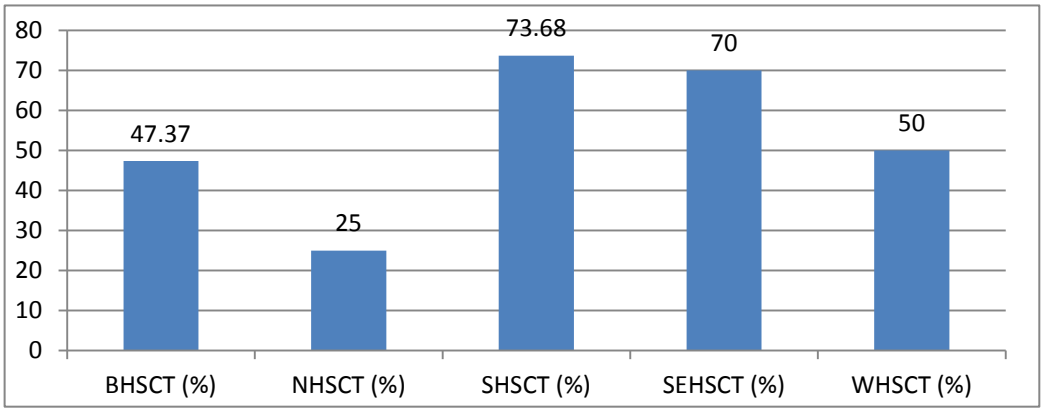
In 90 per cent of files, information was fully completed in relation to patient contact details, with 84 per cent including a description of the presenting condition and 80 per cent stating the reason for referral. The referral letters were legible in 78 per cent of cases. The review team noted that 23 per cent of referrals did not state an explicit reason for referral and the details of the referrer were incomplete in 20 per cent of cases.

5.1.3 Service Users' Medical History

The current medical history of service users was recorded in 59 per cent of referrals, with 55 per cent describing the past medical history. The percentage of the referrals that included a past medical history, and

information on co-morbid mental health presentations is summarised by trusts in figure 2.

Figure 2: Percentage of referrals by trust evidencing a history of co-morbid conditions



5.1.4 Detoxification History

Paragraph 1.2.1.3 of NICE guidelines [CG115] states that:
"When conducting an initial assessment, as well as assessing alcohol misuse, the severity of dependence and risk, consider the:

- extent of any associated health and social problems
- need for assisted alcohol withdrawal"

Reviewers assessed patient files to determine whether the referrer made reference to any detoxification history or any specific needs which the service user might have had, when being referred into addiction services. They found a wide variation across trusts.

In the SHSCT, 42 per cent of referrals contained information regarding a service user's previous assisted withdrawal/detoxification history, compared to 31 per cent in the NHSCT, 25 per cent in the SEHSCT, 18 per cent in BHSCT and 11 per cent of referrals in the WHSCT. The WHSCT however has a separate detoxification referral pathway which may explain the lower percentage.

5.1.5 Use of Screening Tools

NICE guidance recommends that at initial presentation, those with drug and alcohol misuse should have some type of formal assessment, involving alcohol or drug specific screening tools, to assess the nature and extent of their condition. Opportunistic brief interventions such as motivational interviewing should then be provided, where appropriate. The General Practitioner curriculum also recommends that, where appropriate, evidence based screening, brief interventions and effective primary care treatments should be provided for service users with drug and/or alcohol misuse.

In addition the HSCB has a voluntary scheme in which contributing GPs are remunerated to provide screening and brief interventions for alcohol misuse. The enhanced service supports undertaking opportunistic screening of service users over 18 years and makes reference to the use of the NICE audit tool for this purpose.

Reviewers found very limited evidence of any alcohol and drug screening tools being used by GPs, or by other health professionals who routinely refer into addiction services.

Within the SEHSCT, 40 per cent of referrals included information on alcohol and drug use, obtained through the use of screening tools. This compared to 25 per cent of WHSCT referrals and 18 per cent of those within the SHSCT. None of the service users referred to the BHSCT or NHSCT included such information.

5.1.6 Interventions Offered by GP Services

In keeping with the stepped care model, following an assessment, interventions for substance misuse should be offered by GPs, or other members of the primary care team, before service users are referred on to specialist step three services. In addition, information regarding the success or failure of such interventions is required, before a referral is made to a step 3 service. The information contained in the files reviewed in this regard was very limited.

Fifty per cent of patient referrals made from primary care professionals contained no information regarding any interventions that had been offered to service users. There was a lack of information on treatments offered by GPs, or other primary care professionals, included in referrals evidenced in two trusts i.e. WHSCT and NHSCT.

5.1.7 Home and Family Circumstances

Information on home and family circumstances of service users was included in only 42 per cent of referrals yet alcohol and drug misuse has a devastating impact on the individuals affected and their families and communities. Twenty three per cent stated that the patient was a risk to themselves or others (ranging from 6 per cent of NHSCT to 32 per cent of SHSCT and SEHSCT referrals).

5.1.8 Management of Referrals

Referrals of service users were reviewed in terms of how they were managed. Of the 100 files reviewed, 18 patient referrals had been classified as urgent by the GP. Of these, 10 out of 18 breached the two week integrated elective access protocol (IEAP)[13] guidance. This is the target set by the DHSSPS, for

[13]Integrated Elective Access Protocol (IEAP) (DHSSPS referral targets)

management of service users from the point of referral to the point of discharge.

Reviewers then tracked which referrals had been classified as urgent by GPs, which were subsequently re-graded to routine at the One Point of Referral (OPR) into the system. In the Belfast Trust, five of the 20 referrals had been stated as urgent by the GP, yet all of these had been reclassified as routine by the OPR staff. In one of these cases, a service user, with an opiate addiction, referred by their GP for an urgent two week appointment, was not seen by community addictions services until eight weeks after their initial referral. After their assessment the patient was reclassified as a priority. The service user's risk assessment showed that they had a severe mental health problem. The file audit indicated that 95 per cent of the routine referrals were seen within the nine week target.

In relation to providing service users with appointments, the NHSCT management process provides the individual with the earliest appointment in the trust (this could be the same day/next day) and they gradually work through the available priority appointments, in date order, to ensure the person has all options available to them to be seen at the soonest appointment if they so choose. The rationale for this is that the individual is in the best position to decide what is most important/ possible for them i.e. to be seen sooner or in their local area. The trust has indicated that most service users are seen in their local area and all are seen within the Priorities for Action (PfA) target of maximum nine weeks or for priority maximum of 10 working days. However, reviewers found an example of one patient, with severe mental health problems and a previous suicide attempt, who was also considered a risk to others, had been offered three appointments in Ballymena, Portrush and Ballymoney. The patient refused all of these appointments, as they lived in Larne and were unable to travel the required distance.

5.1.9 Variation in Content and Quality of Referral Information

The Royal College of General Practitioners (RCGP) curriculum (2013)[14] highlights that people with drug and alcohol problems are often stigmatised by society and professionals, and that all general practitioners have a responsibility for providing general medical care to people registered with them, who have drug or alcohol problems. Primary care based interventions for drug and alcohol problems can be very effective in reducing physical, psychological and social harm, for both the patient and the community.

The RCGGP curriculum[15] (p7. 2013) recommends that GPs should take an adequate drug and alcohol history, including the physical, mental, social and legal aspects and use screening tools to assess alcohol and/or drug use, when appropriate (both planned and opportunistically).

[14] RCGP Curriculum 2010, revised 14 August 2013 : Statement 3.14 Care of People who Misuse Drugs and Alcohol
[15] RCGP Curriculum 2010, revised 14 August 2013 : Statement 3.14 Care of People who Misuse Drugs and Alcohol

Reviewers noted considerable variations in the content and the quality of referral information, ranging from a short paragraph requesting that the patient be seen in relation to their alcohol drinking patterns, to pages of information outlining the patient's medical history, psychosocial context, previous primary care interventions and involvement with community organisations.

Considerable variation was noted in information provided on the extent and nature of service users' drug/alcohol use, severity of dependence, management of risk and what, if any, steps had been taken to manage this by previous interventions prior to referral. This creates difficulties for trusts in assessing the urgency of a referral.

In a substantial number of cases, details of the patient's medical history had not been included. As the past medical history is relevant to decision making in these cases, the absence of any such detail could result in important information not being taken into account in any risk assessment.

A number of GP referrals had been re-categorised from urgent to routine after initial screening by the addiction services team. In the course of the review of patient files, it was found that one patient who was re-categorised subsequently required to be treated as a urgent priority.

In terms of the re-grading of referrals from urgent to routine, the review team considered that it was important to communicate, at an early stage, the reclassification of the referral to the GP practice who made the initial referral. This means that proper primary care support can be provided for service users while waiting to access specialist services.

Recommendations

1. The HSC Board should review the number and types of standardised referral forms, currently used by HSC trusts, for making referrals into Community Addiction Services, with a view to having one standardised form used regionally.

2. The HSC Board should review the use of screening assessment tools, the type of intervention and treatments made available to help primary care professionals manage substance misuse and harmful drinking.

3. The HSC Board should provide assurances to the DHSSPS that GPs are trained in the use of alcohol and drug screening tools and have appropriate information and knowledge to provide interventions at primary care level.

4. GPs should ensure that relevant details of a patient's medical history are included in any referral made to the trust.

5. GPs and other primary care professionals should be notified at an early stage by HSC trusts if referrals of service users have been reclassified from urgent to routine.

5.2 Service User Experiences of GP Services

A series of focus group discussions were held in each trust to obtain service users' views on their experiences of using addiction services. Existing trust drug and/or alcohol support groups were contacted and agreed to participate, and where necessary, trust staff supported the RQIA review team in facilitating the groups.

There were a total of 35 participants – 22 male and 13 female. All participants had experienced drug or alcohol problems and had received treatment and support from trust community addictions services, drug outreach teams and/or inpatient services. Participants were either currently using services or had previously used addiction services but maintained contact through service user support groups. Participants gave their views on a range of issues associated with addictions services.

Regarding their experiences when dealing with GPs, reports from service users were variable; with some saying they had very good experiences of receiving help and support from their GP.

> "*The GP was very helpful. I saw the addiction team worker as well. The ward saved my life and did me the world of good by doing what they suggest. I had to wait four weeks. I was given Librium by my doctor and was able to keep contact with my GP until I got into the ward. Once she knew I wanted help her arms were wide open. She gave me extra appointments while I was waiting which was good.*" (alcohol dependency for 14 years)

Other service users stated they felt that they were being *"heavily judged"* and that their GP(s) were reluctant to engage with them and find a way to treat them, which made some reluctant to disclose the problems they were having. This was reported to be the case whether the person suffered from alcohol or drug misuse.

Other comments received were:

> "*The GP had not the time, interest, expertise nor experience to treat patients with severe addiction."*
>
> *"It was the luck of the draw whether you got a good GP who could help."*
>
> *"GPs get you out as quick as possible. They don't know where to send you or what to do with you. It's the luck of the draw.*"
>
> **"***My doctor was scared and he didn't want to see me again. Another doctor threw a packet of needles at me and said if you are going to inject, use clean needles. Doctors are scared because they don't know what to do. It took four doctors until I found one who was finally interested in helping me. I just got so depressed and frustrated that I*

wanted help and couldn't get it. That was 10 years ago and I'm still experiencing the same thing now. There are still big barriers."

"GPs don't have a good way. They will wash their hands of you and treat you like someone begging on the street. It's their whole attitude. GPs are not very sympathetic."

Two service users looking for help with cocaine and a heroin addiction said that their GPs told them:

" ..*Coke is not a drug we deal with. No we don't counsel coke heads". You are on your own. Still the same after 13 years.*" (Service user with cocaine addiction)

"*After using heroin for guts of 12 years he gave me one yellow valium and then said "get a job.*" (Service user with heroin addiction)

"*It's scary. I know it sounds silly cause you have done this to yourself. I know they can't take you straight away but you really need the help when you hit rock bottom.*" (Service user with alcohol addiction)

Overall there were mixed views from service users regarding their GP experience. A number were supportive, although, the majority called into question the ability of GPs to deal with service users with a drug/alcohol addiction.

The review team was aware that only a small number of service users had participated in the focus groups. Nevertheless, such views are informative and suggest that further evidence should be sought from GPs to assess how well equipped they feel to deal with service users with a drug/alcohol addiction.

Recommendation

6. The HSCB should ascertain from GPs how well equipped they consider they are to deal with service users with a drug/alcohol addiction.

5.3 Risk Assessment and Management by Trust Staff

5.3.1 PQC Brief Risk Assessment Tool

PQC guidance was revised and reissued in May 2010 to provide "supportive guidance for staff to proactively manage the risk of harm and to deliver safe, effective care provision for service users, their families and for staff".

The guidance included a comprehensive risk assessment tool and a brief risk screening tool which should be completed for all service users who present to mental health services for initial assessment.

As part of the file audit, reviewers examined the compliance of the five HSC trusts, against the completion of the brief risk screening tool.

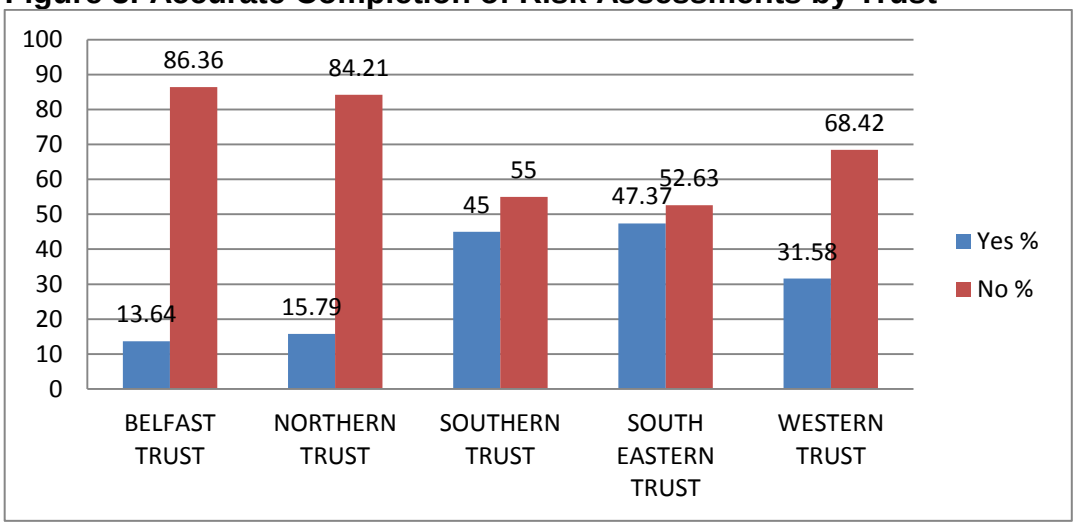
This forms part of step three of the stepped model of care which includes provision of specialist community based alcohol/drug assessment and coordinated care planned treatment and specialist liaison.

5.3.2 Use of Brief Risk Assessment Tool

Of the 100 files reviewed across the five trusts, 97 files contained a brief risk assessment screening tool, completed in the past year, with three files containing no brief risk assessment.

Only 66 of the 97 brief risk screening tools audited were completed accurately in line with PQC guidance (Figure 3). The majority of risk assessments had not been completed fully, with significant sections on the form being left blank. There was evidence that one patient, in each of three trusts, had not received any brief risk assessment. Reviewers were concerned that these service users may not have received an appropriate assessment or service.

Figure 3: Accurate Completion of Risk Assessments by Trust

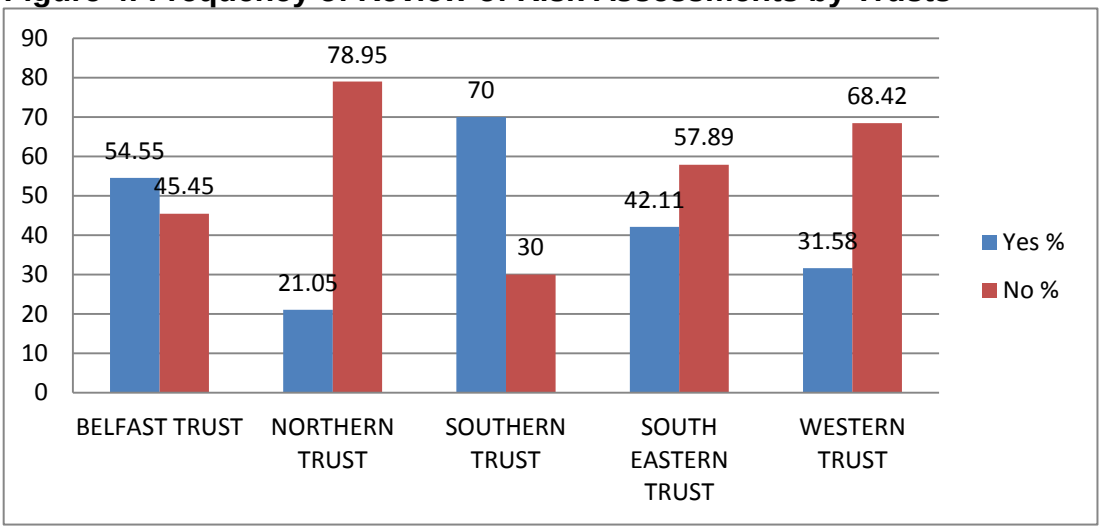


5.3.3 Frequency of Review of Risk Assessments

PQC guidelines state that risk assessments of individuals using addiction services should be "… regularly updated and reviewed as part of the overall care plan for the patient". The guidelines also state that each patient's keyworker "…must remain in regular contact with the service user and his/her family/carers, review the care plan at frequent intervals to ensure that it is being carried out and update it, as necessary" (PQC 2010). The standard expected by the review team in terms of review of risk assessments was that these reviews would be carried out on a six monthly basis and updated as required if any changes occur in the service user's personal circumstances or situation.

Figure 4 shows the extent and frequency with which trust(s) addiction services met the PQC guidelines by reviewing the risk associated with a patient's circumstances. The graph showed that this varied significantly and was not always in accordance with the PQC guidelines. (Figure 4).

Figure 4: Frequency of Review of Risk Assessments by Trusts



Note: Yes%: - refers to the HSC trust meeting the PQC guidelines. No%: - refers to trusts not meeting the PQC guidelines

Patient records indicated that the NHSCT and the WHSCT, in particular, did not regularly review a high percentage of patient's risk assessments, with 78 per cent in NHSCT and 68 per cent in the WHSCT not meeting the six month review standard.

The absence of regular review of patient risk is a significant concern, as changes in patient circumstances could be missed, resulting in potential harm to the patient, or others. This could lead to the needs of the patient not being met or reflected in their care plan.

Recommendation

7. All addiction service staff should ensure that patient risk assessments are reviewed in accordance with the agreed Promoting Quality Care (PQC) guidance issued by the DHSSPS.

5.3.4 Evidence of Co-morbidity of Mental Health Illness and Alcohol/Drug Misuse

The co-occurrence of substance use problems and psychiatric illness is often referred to as “dual diagnosis”. Promoting Quality Care (PQC) guidelines indicate that the overlap between serious mental health problems and alcohol and drug use is significant. Merikangas and Kalaydjian (2007)[16] also noted that the co-occurrence of substance use and mental health problems is very common.

In the RQIA 2013 report, on Access to Evidence Based Psychological Therapies for Adults who Completed Suicide, it was noted that:

- Service users were often passed across teams where there is co-morbid (joint) history of alcohol and drug misuse.
- Service users presenting with a history of self-harm and suicide attempts had been referred from Community Mental Health Teams to Community Addiction Services with no evidence of follow up from mental health services.

It is important that service users with a dual diagnosis are identified at an early stage in order to ensure that they receive appropriate treatment for their conditions and do not fall between teams.

5.3.5 Employment of Dual Diagnosis Staff

The SHSCT employs three dual diagnosis nursing staff, based within the community addictions team who provide treatment and care to service users with a severe mental illness, who also have drug and/or alcohol problems.

The BHSCT employs a dual diagnosis nurse solely within mental health services, with no remit for addictions services.

The SEHSCT employs a dual diagnosis nurse who operates on a consultancy basis in addition to having a small caseload of service users.

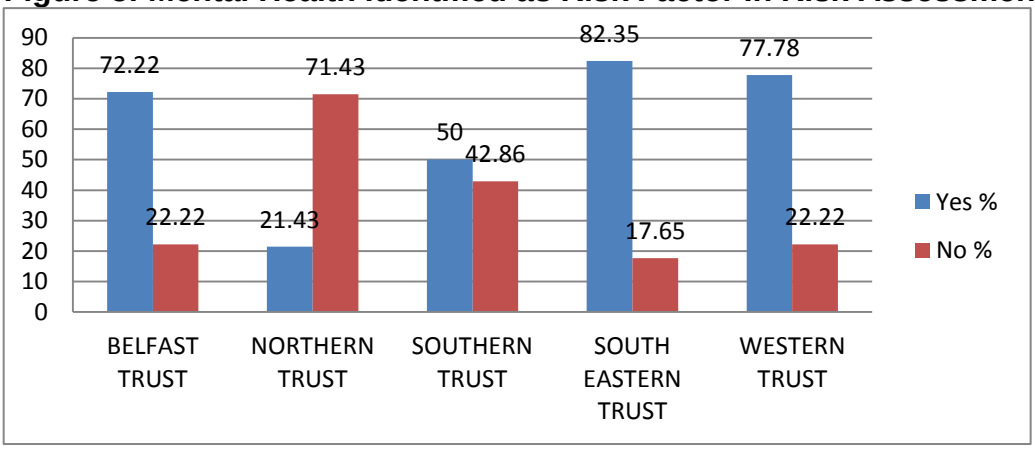
The WHSCT does not currently have a dual diagnosis worker. However, it is considered an aspect of an Alcohol and Drugs Therapist’s work where it is required, working in partnership with a recovery keyworker.

It is unclear if the NHSCT is considering the employment of dual diagnosis nursing staff.

[16] Merikangas, Kathleen R; Kalaydjian, Amanda : Magnitude and impact of comorbidity of mental disorders from epidemiologic surveys

Reviewers noted that significantly high numbers of service users had mental health problems identified as a risk factor within their risk assessments (Figure 5).

Figure 5: Mental Health Identified as Risk Factor In Risk Assessments



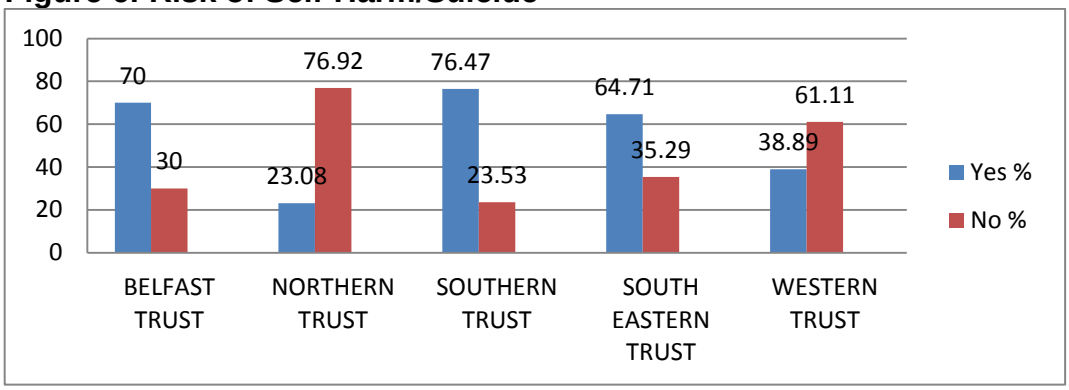
The types of mental health illness noted by the review team included depression and self-harm; those with thoughts of life not worth living, para suicidal behaviour and low mood, as well as some service users who had made numerous suicide attempts. Of the patient risk assessments reviewed across all trusts 60 per cent, identified that service users were at risk as a result of their mental health and co-occurring substance misuse problems.

From the 100 files audited, reviewers identified that over half, 54.6 per cent of service users had been identified as being at risk of self- harm/suicidal behaviour.

The PQC aide memoire identifies risk of self-harm/suicidal behaviour as having the following features:

- Current suicidal thoughts, plans.
- Previous history of suicide attempts/self-harm.
- Suicidal ideation/preoccupation.
- Family history of suicide/or recent loss.
- Access to means.

Figure 6: Risk of Self-Harm/Suicide



The SHSCT (figure 6) recorded the highest rate of service users experiencing self-harm/suicidal behaviour, with 76.4 per cent of service users reporting problems, while the NHSCT recorded the lowest rate, with 23 per cent of service users assessed as at risk in relation to self-harm and suicidal behaviour.

An earlier study undertaken by the NHSCT in June (2013), from a review of community addiction services, found that 74 per cent of the sample had co-occurring mental health problems which encompasses more than self-harm/suicidal behaviour.

5.3.6 Views of Service Users with Co-Morbidity Problems

Some service users through the focus group discussions informed the review team that they were "allowed" to have a mental health problem or an addiction problem but that they couldn't have both.

> *"The addiction unit wouldn't take you if you have a mental health problem and vice versa.*" (Service user with mental illness and drug misuse)

> "*My wife brought me to GP. The night before that I had a psychotic episode and thought my wife was trying to kill me. Police came to house and brought me to my mother's house. I went to see the Doctor after that with an emergency appointment. After 10 minutes of me spilling my guts out, he asked me to leave and said you are wasting my time as an appointment only lasts 10 minutes. It took six weeks of my wife phoning the doctor after that. I have been dual addicted for years taking alcohol and prescription drugs. Not enough staff. Nine times out of ten, it just takes someone to listen to you.*" (Service user with dual diagnosis addicted to alcohol and prescription drugs)

> "*Our culture, we are seen as a nation of drinkers. You're not allowed to say you have a drug problem or alcohol problem. Nobody knows where to send you. But it's starting to change. Dual diagnosis is starting to change things. But there's only four inpatient units in the whole of Northern Ireland for any of the rest of us to get help. You have to deal with the two of them at the one time.*"

Other service users were more positive and said that the care being given in Northern Ireland was much better compared to parts of England or other parts of the UK. One service user was particularly impressed with the speed within which he was able to get a mental health assessment in comparison to his experience of access to services in England.

5.3.7 Service Users in Fear of Losing Children

Some female service users with children stated they were often afraid to ask for help for alcohol or drug misuse, in case they were reported to social services. Some perceived that the social worker was more concerned with removing the children than trying to help the person with the addiction.

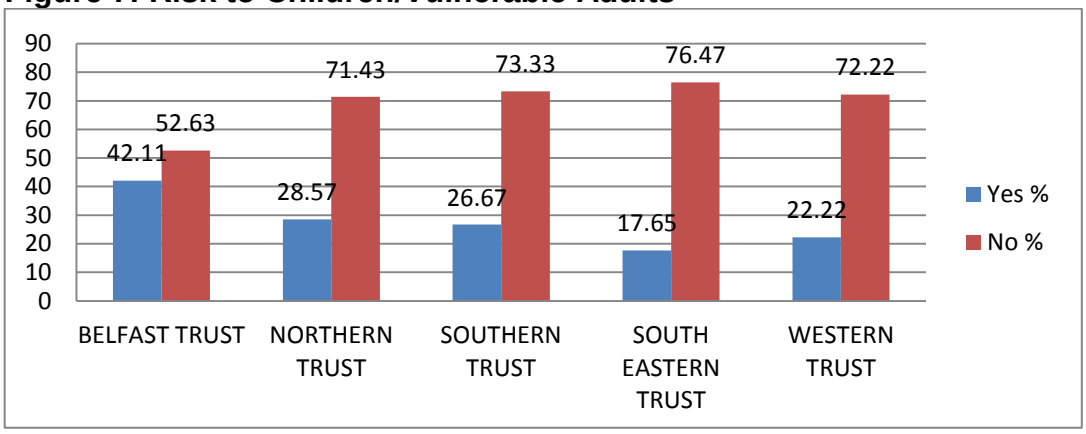
One service user quoted that *"*A lot of women won't come forward because social services are notified. They come in and remove the kids. They do that first and then think, Oh, maybe I should have offered her some help*".*

"I didn't want to go to my GP because he had an obligation to inform social services. But my child-minder had contacted them to say I was drinking. This adds an extra fear. It makes you think at times. Why am I going to bother getting help? Social services are not seeing that I'm trying to improve my life".

5.3.8 Risks identified for Children/Vulnerable Adults

Reviewers found that 27.2 per cent of patient risk assessments evidenced risk with regard to childcare and vulnerable adult issues. The BHSCT recorded the highest incidence of this at 42 per cent. Although brief risk assessments identified childcare and vulnerable adult risks, they did not provide any further information in relation to these areas of concern. The absence of this vital information raises concerns that risks to children and vulnerable adults may go unnoticed (Figure 7).

Figure 7: Risk to Children/Vulnerable Adults



Recommendation

8. All trusts should provide detailed information of any risk to children or vulnerable adults when completing their risk assessments.

5.3.9 Contingency Planning

PQC guidance suggests contingency arrangements should be in place to prevent known situations escalating into a crisis. Steps should be outlined, when, for example, the key worker is unavailable or if the service user is beginning to disengage from care and treatment. Reviewers found that 50 per cent of patient risk assessments did not have a contingency plan to support them in the management of their condition. PQC sets out that a plan should detail specific triggers which are likely to exacerbate a service user's individual risk factors. Speaking to the service user and his/her family/carers about managing a crisis situation is essential, as they know their situation best, and what is most likely to alleviate any problems.

Recommendation

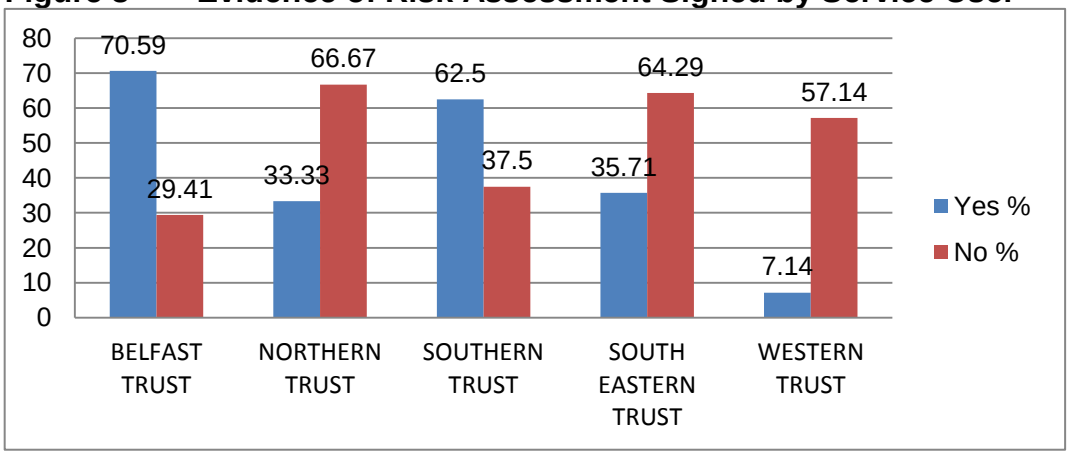
9. All trusts should ensure there is a contingency plan in place for service users if their key worker is unavailable, or if service user shows evidence of disengagement from services.

5.3.10 Patient Signatures

PQC guidance states that a patient's risk assessment should be person-centred and prepared in collaboration with the service user and his/her family/carer. Efforts must be made to ensure that the service user and his/her family/carer understand each element of any care plan. It should be countersigned by the service user and his/her family/carer, if involved, to show that they have read, understood and agreed the care plan and any associated risk management plan. Where the patient has not signed, a reason for this should be recorded in the electronic care record (EPEX) or equivalent contact section if available.

Reviewers noted considerable variation regarding the numbers of risk assessments signed by service users.

Figure 8 Evidence of Risk Assessment Signed by Service User



Over 50 per cent of risk assessments in the NHSCT, SEHSCT and WHSCT contained no evidence of a patient signature (Figure 8). The BHSCT

evidenced the highest number of records of service users having signed their risk assessment. While a patient's involvement in addiction treatment and care is not proved by the presence of the patient's signature, it does provide some evidence that the patient has seen their risk assessment. This in turn supports some of the key indicators in ensuring the provision of effective treatment, as identified by the National Treatment Agency for Substance Misuse.

The use of electronic systems was given as a possible reason for lack of patient signatures, as an electronic record provides no facility for this. Trust staff have indicated that a therapist is expected to discuss and agree the care plan with the patient in every case. A significant variation was also noted in the involvement of carers in signing the risk assessment in each trust. This is not in keeping with the PQC guidance.

Recommendation

10. Staff should ensure that all patient risk assessments are shared with the patient who should be given the opportunity to sign their assessment in accordance with PQC guidance. In the case of electronic recording a record should be made that the care plan has been shared and agreed with the patient, this should be dated and entered in the contact record.

5.3.11 Use of Electronic and Paper Records

To support the implementation of PQC in all trusts, the HSC Board previously made funds available to progress the development of a standardised electronic information system. This has the potential to solve many of the current access and information sharing problems, in relation to risk assessment and management of service users. In a previous review undertaken by RQIA in 2012, it was found that trust staff were not completing documentation in line with the guidance. The previous RQIA report notes that the "introduction of an electronic recording system should help the inconsistencies in recording, as all the fields will be required to be completed". Reviewers found little change regarding the use of electronic recording across trusts, since the previous RQIA review in 2012. A circular issued to all HSC trusts regarding the review of PQC guidance by the DHSSPS stated that "It should be stressed that until a new integrated care pathway and associated documentation are in place, that services should continue current risk assessment and management practice[17]".

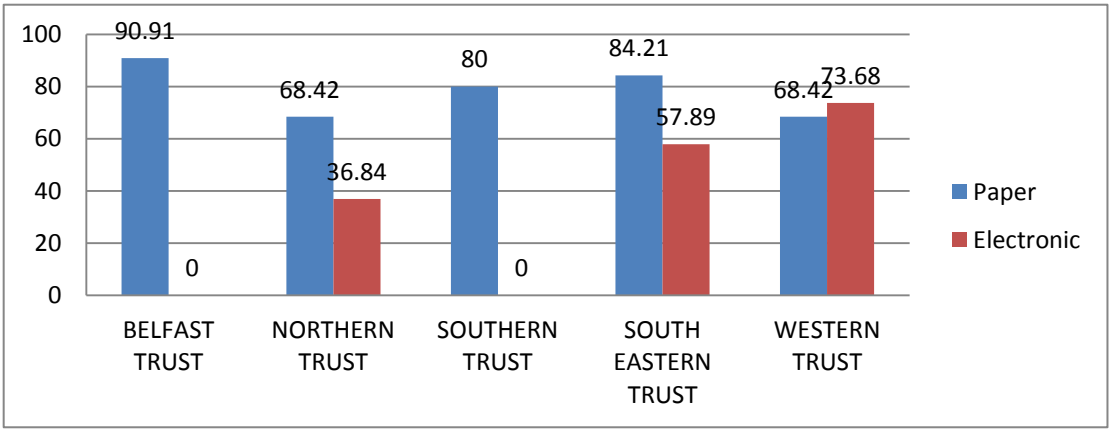
Reviewers found that the NHSCT no longer transferred paper copies of risk assessments into an electronic format pending the determination of the DHSSPS review on PQC regional group decision, regarding how implementation of effective risk assessments would proceed. The BHSCT evidenced over 91 per cent of patient risk assessments were in paper format. This, however, contrasted with the WHSCT who had recorded almost 74 per

[17] Circular issued to trusts on the Implementation of DHSSPS Promoting Quality Care Guidance (2010). DHSSPS August 2014

cent of risk assessments in electronic format, although they retained 68.5 per cent of risk assessments in a paper format. Figure 9 shows that the percentage of electronic and paper risk assessments varied across trusts.

In the WHSCT all care plans are stored electronically therefore there is no facility for service users to sign these. However, the trust has indicated that every therapist discusses and agrees the care plan through a process of collaboration and this is noted in the EPEX contact section.

Figure 9: Records of Patient Information



Recommendation

11. All trusts should progress the roll out of electronic information systems to ensure that completed patient risk assessment tools are available to enable relevant staff to be kept informed promptly of any ongoing risks.

5.4 Review of Assessment and Interventions for Alcohol Dependency and Drug Misuse within Addiction Services

5.4.1 Brief Triage Assessments

In accordance with best practice NICE guidelines, all adults who misuse alcohol, referred to specialist alcohol services, should have a brief triage assessment completed. This assessment involves the use of specific tools, to assess a number of areas related to alcohol dependence, listed below:

- The pattern and severity of the alcohol misuse using the Alcohol Use Disorders Identification Test (AUDIT) and severity of dependence using the Severity of Alcohol Dependence Questionnaire (SADQ).
- The need for urgent treatment including assisted withdrawal.
- Any associated risks to self or others.
- The presence of any comorbidity (joint illnesses) or other factors that may need further specialist assessment or intervention.

Of the 100 files reviewed across the five trusts demonstrating alcohol and drug misuse, the majority of files assessed (n=79) were in relation to alcohol dependency. However, in the NHSCT, of the files reviewed, the majority of these related to service users being treated for drug misuse.

Reviewers found that there was limited evidence across the trusts of the use of brief triage alcohol assessment tools. The WHSCT reported that in the alcohol and drugs service, a paper based triage is carried out for every referral coming from the GP or other referral sources. Table 1 shows that only a small number of files in each trust showed evidence of use of recommended triage tools.

Table 1: Use of Brief Triage Assessment Tool for Alcohol Dependency

Brief triage assessment to assess the following:	**Number of patient files that showed evidence of audit tool questions**				
	BHSCT (n=17)	**NHSCT (n=5)**	**SEHSCT (n=16)**	**SHSCT (n=16)**	**WHSCT (n=15)**
The pattern & severity of alcohol misuse: (using [18]AUDIT, SADQ)	3	3	6	6	8
The need for urgent treatment including assisted withdrawal?	2	1	2	6	6
Any associated risks to self or others?	6	2	5	6	7
The presence of co-morbidities/ other factors that need further specialist assessment or intervention.	9	4	6	12	7

5.4.2 Comprehensive Assessments

NICE clinical guideline 115 for alcohol dependence and guidelines 4, 51 & 52 for misuse of drugs and other substances, state that a comprehensive assessment should be carried out to assess multiple areas of need. It should include a clinical interview, use relevant and validated tools and cover a wide range of areas including:

- alcohol use including consumption
- patterns of drinking
- dependence
- alcohol related problems
- other drug misuse
- physical and psychological and social problems
- cognitive function and readiness and belief in ability to change

Of the files reviewed in each trust for alcohol dependency (Table 2), the majority included evidence of a comprehensive assessment being undertaken in a structured clinical format. In the NHSCT, only five files were able to be audited for alcohol dependency as the remainder is related to drug misuse. Assessments identified physical, psychological and social problems, along with an assessment of the patient's belief in their ability to change. However, even though there was evidence of an assessment, a lack of use of relevant and validated tools to assess alcohol dependency was noted as a problem, particularly within the BHSCT and NHSCT areas. This has the potential to weaken the robustness and quality of the assessment.

[18] Severity of Alcohol Dependence Questionnaire (SADQ); Alcohol Use Disorders Identification Test.

Table 2: Comprehensive Assessment for Alcohol Dependency

Section 2: Comprehensive assessment	BHSCT (N=17)	NHSCT (N=5)	SEHSCT (N=16)	SHSCT (N=16)	WHSCT (N=15)
Was a Comprehensive assessment carried out?	14	4	12	16	14
Did it assess multiple areas of need?	13	4	12	13	14
Was it structured in a clinical interview?	13	4	12	16	14
Did it use relevant and validated tools?	5	0	3	3	8
Did it cover the following areas:					
(a) alcohol use	8	3	6	11	11
(b) alcohol consumption	12	4	8	13	10
(c) Dependence using SADQ or LDQ[19]	0	0	6	0	9
(d) alcohol related problems (e.g.[20] APQ)	0	0	3	3	9
(e) other drug misuse (e.g. Over the counter medication)	9	1	6	1	8
(f) physical health problems	11	3	11	14	11
psychological & social problems	11	4	10	12	12
(h) cognitive function (e.g. [21]MMSE)	0	0	6	0	9
(i) readiness & belief in ability to change	12	2	9	5	9

5.4.3 Delays in Receiving Treatment

Within addiction services, routine referrals will be seen within six weeks while urgent referrals are seen within two weeks. It was concerning to note that after an initial assessment by community addiction services, service users often waited for a further period of at least six weeks to begin treatment. The consequence of this is that service users could suffer further physical and emotional ill-effects as a result of their addiction.

Service users expressed concerns about the length of time they had to wait, both for an initial assessment and the initiation of treatment by community addiction services. They believed the wait had a detrimental effect, resulting in them becoming further discouraged and suffering from the physical effects

[19] Leeds Dependence Questionnaire (LDQ)
[20] Alcohol Problems Questionnaire (APQ)
[21] Mini-Mental State Examination (MMSE)

of their addiction. HSC trusts are expected to comply with the nine week waiting list.

5.4.4 Interventions Offered For Alcohol Dependency

NICE Guidance recommends that service users with harmful alcohol dependency and even those with mild alcohol dependency are offered psychological interventions that focus specifically on alcohol related cognitions, behaviour problems and social networks.

Table 3 shows the number of service users within community addictions services in each trust whose files indicated they were offered any kind of psychological intervention.

Table 3: Number of Patients Offered *Psychological Interventions for Alcohol Dependency

Trust	Patients offered treatment	Patients not offered treatment	Number of files reviewed
BHSCT	11	5	16
NHSCT	3	1	4
SHSCT	9	7	15
SEHSCT	5	11	16
WHSCT	12	3	15

*Psychological interventions: This focuses specifically on alcohol-related cognitions, behaviour, problems & social networks

Although patient files showed evidence of psychological interventions in terms of group therapy and support, reviewers did not find evidence of care or treatment plans incorporating specific time limited, high intensity psychotherapies e.g. cognitive behavioural therapy (CBT), motivational enhanced therapy or behavioural therapy, as a proven evidence based therapy for alcohol dependency (Table 3).

Examples of treatment interventions for these service users were provision of a weekly support programme, relaxation therapy, education and 'one to one work'. Service users within the stabilisation and were routinely offered some brief intervention/harm reduction, education, or referral to another agency such as Alcoholics Anonymous (AA), as well as being asked to complete a drink diary to capture the frequency of substance misuse and associated thoughts and feelings. An example of treatment for a patient with alcohol dependency, who drank a ten glass bottle of whiskey a day, was diary work, brief intervention/harm reduction and education for alcohol and codeine addiction.

Often service users with a primary diagnosis of alcohol abuse also had evidence of mental health problems. These would manifest in a number of ways:

- self-harm and/or depression
- thoughts of life not worth living

- numerous suicide attempts
- overdose
- cutting behaviour
- binge drinking
- substance misuse and anxiety

Table 4 shows the number of patient files which showed evidence of psychological interventions being provided for mental health problems. Service users not offered treatments for mental health problems did not have mental health problems requiring this intervention.

Table 4: Number of Patients Offered Evidence Based Interventions for any Mental Health Problems

Trust	Patients offered treatment	Patients not offered treatment	Number of files reviewed
BHSCT	4	10	14
NHSCT	3	1	4
SHSCT	7	7	14
SEHSCT	5	11	16
WHSCT	6	9	15

Recommendations

12. Therapists should identify the therapeutic model and evidenced based interventions in their care treatment plan.

13. Guidance on the use of NICE recommended assessments and interventions for managing substance misuse and harmful drinking should be available to all staff working within Community Addiction Services.

14. All trusts should audit at least on an annual basis, clinical records in relation to the use by staff of NICE recommended psychological interventions for service users with drug and or alcohol dependency.

5.5 Review of Assessment and Interventions for Drug Dependency within Addiction Services

Although 100 files in total were reviewed across the five HSC trusts, there were only 26 files assessed in relation to drug misuse across all of the trusts due to the availability of information. The majority of service users came into the service via their GP, but other routes were through mental health, or prison services, or from voluntary organisations.

All adults who misuse drugs and who have been referred to specialist drug services should have assessments carried out in line with NICE guidelines 4, 51, and 52 for misuse of drugs and other substances.

The NHSCT operates a centralised referral system with referrals accepted from general practitioners, hospital doctors or consultants. The Addiction Service offers treatment, advice, and information to individuals over the age of 18 years who are experiencing problems with alcohol or drugs. The type of services offered for service users included addiction day treatment, substitute prescribing, drug outreach team, drug arrest referral team, prescribed medication misuse team, inpatient treatment services.

Service users are not able to refer themselves directly into the addictions service, with the exception, of the community clinic in Ballymena in the NHSCT, which specialises in treating service users with intravenous drug use. The review team found that 61 per cent of service users were referred by their GP into addiction services with other referrals being made by mental health service, prisons or other health professionals.

NICE guidance states that people presenting for opioid detoxification should be assessed to establish the presence and severity of opioid dependence, as well as misuse of and/or dependence on other substances, including alcohol, benzodiazepines and stimulants. Reviewers found that many service users who had problems with drug misuse also had problems with alcohol abuse and there were service users who had multiple admissions for detoxification.

One example was noted, where a referral was made by the GP for a patient with alcohol problems and an opioid addiction, with a six month history of abusing codeine, taking 48 co-codamol daily. The GP referred the patient into community addiction services. A risk assessment showed the patient had mental health problems and thoughts of life not worth living. The treatment involved brief intervention, harm reduction and education, as well as completing a drink diary for alcohol abuse.

Fifteen service users out of 26 were considered to be opioid dependent and 13 of these expressed an informed choice to become abstinent. Best practice suggests that the first line of treatment offered for this is Methadone or Buprenorphine. In addition to receiving assessments and medical interventions, reviewers found that 22 service users demonstrated they had physical health conditions with actions taken in relation to these for 13 service users. In nine out of 26 files, reviewers found that there was some expectation for the patient to be a minimum of 12 hours drug free prior to the time of each contact.

Twenty-two service users demonstrated they were still misusing substances throughout their treatment. A number of risk factors were identified for service users misusing drugs. In 26 files sampled, there were 10 files where family members were misusing drugs. Twelve out of 26 files audited showed the patient was considered to be vulnerable and disadvantaged. In addition, nine patient files showed the person to be at risk either to themselves or others. Five service users within the audit were referred inappropriately to mental health services.

Seven service users out of 26 were referred to other services (such as social care, housing, employment support). In addition to other support given, eight patient files showed evidence of interagency working.

Reviewers found that treatment interventions for drug addiction were offered to 16 people, but focused on motivation type therapy. Only a small number of service users were given information about self-help groups.

Reviewers took the opportunity to speak to staff about their views on services provided to people with drug addictions. Nursing staff consider they should be available for service users in the community, to provide ongoing counselling and support to help prevent relapse. Service users reported that in the past, staff had been able to visit service users in their own home or else meet with them for a coffee and a chat. However, service users stated that the caseload of staff was just too big to enable them to do that and that service users were being disadvantaged because of this.

From the focus group discussions, service users going through treatment programmes said they sometimes experienced inconsistencies in the service. In a particular trust service, service users at different stages of their treatment attending the clinic were meeting service users who were still abusing drugs. This was difficult for service users trying to abstain, as it put them in a vulnerable situation.

One service user's view in relation to this was:

> "..*Years ago addiction teams used to come to your house and see if you were drinking or alive. Now people have been found dead because they couldn't get to the addiction service.*" (Service user with drug addiction)

This situation is made worse when the person had no one to accompany them to the clinic to provide support.

A service user commented

> "People are at different stages of drug use. I have someone going in with me but there are a lot of ones walking in there on their own." (Service user with drug addiction)

5.5.1 Support for Service Users

A number of trusts shared specific examples of community based support services with the reviewers, although RQIA is aware that community and voluntary based support groups are also available in other trusts.

The SHSCT offers a programme of psycho-education and support through a group called Breakthru. Group Education and Motivation Support (GEMS) is delivered in partnership with the Community Addiction Team. It is a 10 week rolling programme which explores addiction and its impact. Groups are held

weekly in Newry and Dungannon and referrals are made via the Community Addiction Team. Reconciliation, Education and Community Training (REACT) also provides the same service in the SHSCT for groups in the Craigavon area. REACT was formed in 2002, with a focused approach on addressing community need through reconciliation and community relations work, education, youth development and training. The organisation's core work is aimed at developing whole communities, with an emphasis on reaching out to those most marginalised, while also encouraging the value of diversity.

Service users who used Breakthru spoke very highly of this programme. However, their concern was how they would be able to cope after the programme had finished in terms of having ongoing support to help them manage their addiction.

In the NHSCT, approximately 50 per cent of individuals with alcohol and non-injecting drug dependency, who engage in treatment attend a 'Changing Together Group' which is run in a number of locations across the trust and a proportion of these individuals may opt to engage in a 'Keeping it Going Group'. Both of these groups use structured psychological therapies. Individuals also have access to manualised therapies for anxiety and mild to moderate depression that are provided through psychology staff. Higher intensity psychological interventions are provided by a consultant psychologist and clinical psychologist. A group therapist provides an analytical group for individuals with complex comorbid presentations.

Service users who had used inpatient units spoke very highly of their experiences and the care and support they received from staff. Service users felt that they needed the structured environment and regime which provided the time and space to help them come to terms with their alcohol or drug misuse problems. This is reflected in the inspection reports of the four inpatient services on the RQIA website.

Service users who were part of other support groups were very positive about the support they received, not only from key workers and other staff, but also from other service users within the groups. Many service users found support groups very beneficial. These included the drug outreach team for people with addictions in the BHSCT and the service user group in the NHSCT.

6.0 Quality of Discharge Information and Follow-up Arrangements for Patients with Addictions

The quality of discharge information provided by trust staff, to the patients' GPs was examined by the review team. Information on discharge is important in ensuring that the patients' GPs are aware of the treatment they had received and to enable them to provide any necessary follow up care.

Table 5 below shows types of information recorded for each trust in relation to patient discharges

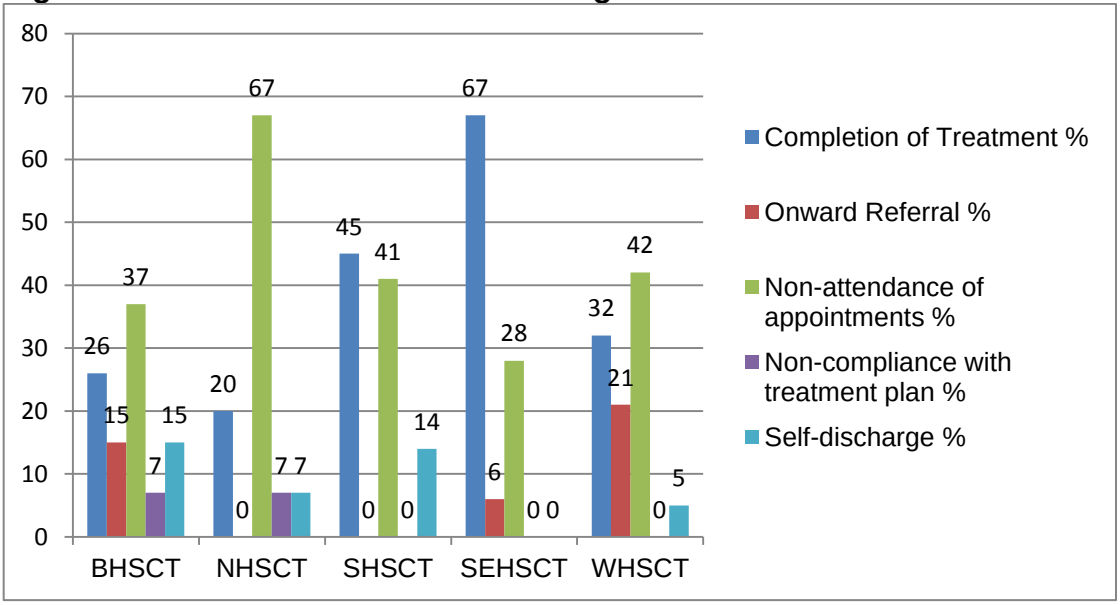
Table 5: Discharge summary and follow-up letters to patient's GP

Discharge summary and follow-up	BHSCT		NHSCT		SHSCT		SEHSCT		WHSCT	
	Yes %	No %	Yes %	No %	Yes %	No %	Yes %	No %	Yes %	No %
Are there any actions for the GP recorded?	55	45	16.67	83.33	70	30	36.84	63.16	26.32	73.68
Advice recommendations and future plan recorded?	57.14	42.86	5.88	94.12	52.63	47.37	55	45	38.89	61.11
Details about person completing discharge plan	70	30	17.65	82.35	65	35	36.84	63.16	57.89	42.11
Reason for discharge given?	100	0	72.22	27.78	100	0	84.21	15.79	94.74	5.26
Follow up/ review to other service recommended?	35.71	64.29	0	100	40	60	52.94	47.06	31.25	68.75

Over 90 of the 100 files reviewed included a discharge letter to the GP, containing accurate patient details and the date of discharge from the service. Relevant clinical information was also available in 75 per cent of files. This included details of physical and mental health problems and any pertinent issues related to their attendance and management. Discharge letters were provided both as a result of completion of treatment or non-attendance at appointments.

The main reasons for patient discharge are shown in figure ten. Self-discharge refers to the patient leaving the service on a voluntary basis, which could be for a variety of reasons e.g. moving away to another area; agreed completion of treatment, or the person did not wish to continue with treatment.

Figure 10: Reasons for Patient Discharge from Addiction Services



The percentage of patients recorded as having been discharged following completion of treatment was highest in the SEHSCT (Figure 10). This was most likely due to the high proportion of patient files which related to inpatient treatment, relative to the number of files that were audited overall.

The NHSCT had a higher proportion of service users who did not attend (DNA) for appointments, which amounted to ten service users out of 16 (figure 10). The NHSCT indicated that they regularly monitor DNA rates and that the DNA rate is low compared to some other trusts. All discharges are followed up with a letter to the GP to ensure that they are informed of the non-engagement and can follow up with their patient in primary care as appropriate. Reviewers did find that other trusts also sent discharge summary letters to GPs. Reviewers noted that , in some instances, there were no GP letters, including service users who did not attend appointments. In addition, there were instances when GP letters were sent but there were no actions for GPs recorded.

Recommendation

15. In light of information arising from the confidential inquiry which highlights the role of alcohol and drugs in patient suicides and an increase in completed suicides in service users who have missed appointments, particular attention should be paid by staff to service users with dual diagnosis/co-morbid conditions to ensure that they are not falling between services.

7.0 Views of Services Users with Addiction to Alcohol and Drugs

During focus groups service users were asked for their views regarding a wide range of issues associated with addiction services. Service users were asked about their views and experiences of accessing addiction services. Some of their comments are recorded below.

7.1 Access to Services

> "*They need to act on that window of opportunity when people want to come off. Heard about methadone/ subutex programme. Within three days was on script. But some people have to wait weeks or months and it is ridiculous. Three weeks can be a life time. In Belfast people wait 4-5 months to get onto opiate programme. Now on maintenance programme. I feel settled and treated well. Before this it was carrot and stick*." (Service user with opiate addiction)

> "*Same trying to get into community addiction services. Six week wait from referral to access of services. Difficult work to put yourself through. You present yourself to the GP and need help at that point, but there is no help offered.*" (Service user with drug addiction)

> "*The wait is ridiculous. You have the clarity of thought to approach the GP, so the treatment should be urgent. Waiting only makes it worse. There's a wait of 4-5 months for a maintenance programme.*" (Service user with drug addiction)

> "*From seeing the GP it took nine weeks to see the addiction team and 9 weeks to get into the ward. It wasn't quick enough to get seen. I was hanging, waiting on an appointment which made me hit rock bottom. I found it very hard to go into the ward.*" (Service user with alcohol addiction)

A number of service users said that it was often the case that they would have to wait up to nine weeks before they got an appointment with the community addictions team for an initial assessment.

Many indicated that they then had to wait a further three months after this initial assessment for another appointment with the community addiction team (CAT). Some service users were unclear why the initial assessments were undertaken by a social worker and not by a doctor.

7.2 Support from Addiction Services

Reviewers heard very positive feedback from ex-service users from ward 15 (Shimna House) in the SEHSCT and also from support group members from Omagh in the WHSCT. Service users indicated there was a lot of support offered, regardless of which trust service users came from, once they had gone through their inpatient programme.

"It has been a very positive experience. I wouldn't be here as my drinking led me to suicide. They just don't treat the person, they look at us as a family. I'm very grateful it was there." (Service user with alcohol dependency describing experience of inpatient unit)

*"*I'm sitting here alive today because of the addiction unit." (Inpatient unit experience of service user with alcohol addiction)

"Went into inpatient unit and didn't want to go home. Got into it through the GP. Was a great experience, whenever I did get into it." (Service user with alcohol addiction).

"*I went into the ward. I'd been involved with the mental health team and had to wait 4 weeks. Can't fault my GP who got me in touch with addictions team. Got referred into ward. Wasn't ready at the time. Another time told GP I was going to take my own life. Got a bed straightaway in the ward. They did save my life. I love coming down to ward meetings on a Tuesday.*" (Service user with mental illness and addiction to prescription drugs)

"*During the six week programme about alcohol and detrimental effects of it I got to know myself as well. I realised through the programme that all the sides of me had to be addressed. It doesn't matter what the situation is, you will try and justify what you are doing.*" (Patient with alcohol addiction)

"*The ward pointed out my pattern of drinking which I had taken as the norm. This made it easier to accept. Once you started to see the pattern of the drinking and where it was taking you it became a lot easier to accept. I find AA helpful and AL anon helpful to my wife that gives her a good understanding of what the problem is.*"

"*Inpatient service would be like jail to me. You can't really hide away from it. I think this is better cause you are living in reality.*" (Service user supporting treatment in the community)

7.3 Methadone Programme

"Methadone programme is very good. Pity it wasn't there 20 years ago. Made massive difference. Also get talk therapy and with psychiatrist. Most of people who didn't stick with the programme are now dead. I'm still an addict but it gave me back my quality of life. It's there for me whenever I want from opiate abuse point of view." (Service user with opiate addiction on methadone programme)

"*In the late nineties there was no maintenance programme. I got a place on the ward but it was geared towards alcoholism. I'm now on a maintenance programme. I feel settled and treated well. Before this it was carrot and stick.*" (Service user with an opiate addiction)

7.4 Needle Exchange Programmes

Service users found that the needle exchange programmes run by pharmacists presented them with a lot of problems, in that opening times were often restricted, for e.g. not being open on a Saturday.

There were mixed views regarding needle exchange programmes with some service used giving a positive message but others felt they were being unfairly stigmatised. Generally those who had been part of a methadone programme were positive about their experience.

> "*At 6 pm on a Friday needle exchange shuts. Need a van that goes round. Needle exchange closes on a Saturday*."

Some service users described their experiences of local pharmacies and said that they were often not given the full equipment that had been prescribed for them from pharmacists on the needle exchange programme and that this happened too often to be a mistake.

Users felt that they were also often being unfairly targeted by the police when they went to the pharmacist, as they would be searched afterwards. They felt they were being responsible in trying to get help and to use clean needles but were being discriminated against. One service user was asked by a pharmacist whether she had children. Service users said there was good support for the work being carried out by the Public Health Agency (PHA) in relation to the needle exchange programme.

> "*The Public Health Agency have been brilliant. They want to do away with term needle exchange*. " (This is an opinion expressed by service users and not a statement of fact from the Public Health Agency).

Some service users said there "there is a punishment culture" which they felt the Public Health Agency was trying to change and move away from the needle exchange mentality of exchanging one dirty needle for a clean needle. Service users wanted to emphasise that they are being sensible and responsible in going for these types of programme.

7.5 Following Discharge

> "*You're expected to go to AA and if it doesn't work for you you've nothing. Friend threw himself in front of train when psychiatrist said he didn't need to see him anymore. Psychiatrists don't want to see you if you have a drink problem and vice versa. If you don't go to AA you have nothing.*" (Service user with alcohol addiction)

> "*I think here we are very fortunate. There is an open AA meeting on Monday night and meditation on Tuesday is very beneficial. You feel*

like part of a family. Ex -patients on a Thursday night. We are very fortunate having these. Last Monday there is an AL anon. There is a women's group and men's group. There is a group for patients who didn't like the structure of AA."

"*I don't do AA and every Wednesday and every Thursday I go up to men's meeting and ex-patients meeting.*"

"….*I've basically the same problems. I'd like to be sitting here today saying things have changed but they haven't. All the same problems are there. I find it harder today. There is a reticence from statutory bodies to talk to people. I'm surprised. We thought access was easier but our group said it wasn't*." (Service user with alcohol dependency for over 20 years)

"*Service helped me to recognise that I was a binge drinker. Lisburn Support group is great". "One to one makes you feel that you are not a bad person. I'm dealing with it.*" (Service user with alcohol addiction on the support received from Lisburn support group)

"*Ten years ago you were punished if anything found in your urine. Now it's totally changed for the better. It's not socially accepted but it's a lot more accepted than it was 10 years ago. You're given a name, you're not a number anymore. They actually do care.*" (Service user with drug addiction)

"*When I left the unit I was worried. Will they think now I've done my 6 weeks, I won't need any counsellor sessions and it wasn't like that. They kept following me up. It's been eight months since I finished. So it's great to have that support there as it gives me that confidence to have that counselling.*"

"My key worker knew exact plan as to how follow up would go. It was available to me for over 12 months. I don't do AA. In my opinion I find it very negative. – Process was very positive. I need things to be very clear." (Patient being discharged from a six week in patient programme).

"*You must have a goal. You need something to aim for. I know when I got out just knowing I was seeing an addiction nurse was enough to keep me going. The community addiction alcohol addiction nurse does the whole of South Down.*" (Service user with alcohol addiction)

One of the main messages from service users was the difficulties they faced on discharge from addiction services. They felt that the support they received is vital for them in maintaining their recovery.

8.0 Conclusions

The review team audited 100 patient files involving the assessment and management of risk, throughout the patient journey in addiction services, from initial referral, to discharge and the nature of their follow-up arrangements.

When service users use alcohol and drug services, they are often at their most vulnerable and particularly those who have mental health issues with associated drug and alcohol misuse problems. Service users with alcohol and drug problems have been identified in previous reports as requiring particular types of interventions.

A substantial number of service users were noted to have a strong history of mental health problems, suicidal ideation, depression and self-harm including multiple suicide attempts. Some service users interviewed by the review team, vented frustration about the length of time they had to wait for an initial appointment and subsequent delays in obtaining further appointments.

Over half of referrals into addiction services were made by GPs (59 per cent) with the remainder from other professionals, e.g. substance misuse liaison service in acute hospitals. A one point of referral (OPR) system, replacing direct GP referrals, operates in two out of the five health trusts which triages service users before they are referred into community addictions or mental health services. Whilst the review team did not review one point referral systems, they spoke with some staff involved in addiction services. Some staff reflected on the frustration expressed to them by some GPs, by not being able to refer directly to the addiction services. During the OPR triage process, referrals may be re-categorised in terms of their priority by downgrading them from urgent to routine. The review demonstrated that a number of urgent GP referrals had been reclassified as routine at the OPR stage. Reviewers consider it good practice for staff involved in addiction services, to inform GPs if service users initially referred by them as urgent, are re-categorised as routine.

Variation was noted in the content and quality of referral information, with no standardised approach being used across trusts. There was little evidence of alcohol or drug screening assessment tools being used to inform the decision to refer service users into more specialist services. This makes it more difficult for community addiction services to properly assess the urgency of the referral.

There was little evidence of the use of NICE assessment tools across the five trusts but most notably in the BHSCT and NHSCT areas. These tools provide a basis for a comprehensive assessment to be undertaken and help ensure that all areas affecting a patient with substance misuse are fully addressed in a holistic way, involving both the patient and their family. Their lack of use has the potential to weaken the robustness and quality of the assessment. Inconsistency still exists in the use of paper and electronic records in the Belfast and Northern trusts. This should be reviewed by the HSC Board for

consistency, as this is a restated recommendation from the RQIA Review of PQC in 2012.

The audit sample could not be considered as totally representative due to the fact that at least one third of the service users within the NHSCT did not attend (DNA) their appointments. The DNA status could be for a number of reasons such as service users' ongoing substance misuse problems and/or any existing mental health issues. They were subsequently discharged, as a result of their DNA status. Particular attention should be paid by trusts to service users with co-morbid conditions to ensure they do not fall between services.

It is positive that the Alcohol and Drug Commissioning Framework aims to improve consistency of service provision across HSC trust areas. As the Framework is implemented it will be essential that variation is reduced at all levels of service provision. This includes early screening, brief intervention and treatment in primary care.

Based on the findings of this audit, further monitoring is required by trusts to ensure that all staff adhere to PQC and other best practice guidelines in respect of risk assessment and risk management in addiction services.

9.0 Recommendations

Referral into addiction services

1. The HSC Board should review the number and types of standardised referral forms currently used by HSC trusts for making referrals into Community Addiction Services with a view to having one standardised form regionally.

2. The HSC Board should review the use of screening assessment tools, type of intervention and treatment made available to help GPs manage substance misuse and harmful drinking.

3. The HSC Board should provide assurances to the DHSSPS that GPs are trained in the use of alcohol and drug screening tools and have appropriate information and knowledge to provide intervention at primary care level.

4. GPs should ensure that relevant details of an patient's medical history is included in any referral made to the trust.

5. GPs should be notified at an early stage by HSC trusts if referrals of service users have been reclassified from urgent to routine.

6. The HSC Board should ascertain from GPs how well equipped they consider they are to deal with service users with a drug/alcohol addiction.

Risk Management

7. Addiction service staff should ensure that patient risk assessments are reviewed in accordance with the agreed Promoting Quality Care (PQC) guidance issued by the DHSSPS.

8. All trusts should provide detailed information of any risk to children or vulnerable adults when completing their risk assessments.

9. All trusts should ensure there is a contingency plan in place for service users if their key worker is unavailable or if service user shows evidence of disengagement from services.

10. Staff should ensure that all patient risk assessments are shared with the patient who should be given the opportunity to sign their assessment in accordance with PQC guidance. In the case of electronic recording a record should be made that the care plan has been shared and agreed with the patient, this should be dated and entered in the contact record.

11. All trusts should progress the roll out of electronic information systems to ensure that completed patient risk assessment tools are available to enable relevant staff to be kept informed promptly of any ongoing risks.

Assessment and treatment of drug and alcohol misuse.

12. Therapists should identify the therapeutic model and evidenced based interventions in their care treatment plan.

13. Guidance on the use of NICE recommended assessments and interventions for managing substance misuse and harmful drinking should be available to all staff working within Community Addiction Services.

14. All trusts should audit at least on an annual basis, clinical records in relation to the use by staff of NICE recommended psychological interventions for service users with drug and or alcohol dependency.

15. In light of information arising from the confidential inquiry which highlights the role of alcohol and drugs in patient suicides and an increase in completed suicides in service users who have missed appointments, particular attention should be paid by staff to service users with dual diagnosis/co-morbid conditions to ensure that they are not falling between services.

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