Northern Ireland
Assembly

Committee for Health
Room 419
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From: **Éilis Haughey, Clerk to the Committee for Health**

Date: **xx September 2020**

To: **Lucia Wilson, Clerk to the Public Accounts Committee**

Subject: **Public Accounts Committee Inquiry into Addiction Services**

Dear Lucia,

Thank you for your correspondence regarding the Public Accounts Committee's inquiry into the NIAO's report on Addiction Services, which was considered by the Committee for Health at its meeting on 17 September.

The Committee heard evidence from the Northern Ireland Alcohol and Drugs Alliance on addictions services on 21 May, and agreed to forward a copy of the Official Report for this session to you, for the PAC's information.

The Committee for Health intends to consider the matter of addictions again in the future, and would welcome updates on the progress of the PAC inquiry, which will inform its future consideration.

Kind regards,

Éilis

Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

COVID-19 Disease Response: Addiction Services

21 May 2020

NORTHERN IRELAND ASSEMBLY

Committee for Health

COVID-19 Disease Response: Addiction Services

21 May 2020

Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Mr Alex Easton
Ms Órlaithí Flynn
Mr Colin McGrath
Mr Pat Sheehan

Witnesses:

Mr Alex Bunting	Addiction NI
Mr Mal Byrne	Extern
Mr Iain Cameron	Extern
Mr Eoin Ryan	Simon Community NI
Mrs Anne-Marie McClure	Start 360

The Chairperson (Mr Gildernew): I welcome Mrs Anne-Marie McClure, who is the chief executive officer of Start 360 and the chair of NIADA. Are you there OK, Anne-Marie?

Mrs Anne-Marie McClure (Start 360): I am indeed, Colm.

The Chairperson (Mr Gildernew): Thank you. Mr Eoin Ryan is the head of harm reduction services with the Simon Community. Are you there, Eoin?

Mr Eoin Ryan (Simon Community NI): I am, yes.

The Chairperson (Mr Gildernew): Thank you, Eoin. Mr Alex Bunting is the director of Addiction NI. Alex, are you there?

Mr Alex Bunting (Addiction NI): I am here, yes.

The Chairperson (Mr Gildernew): Thank you. Mr Mal Byrne is the assistant director of addictions and mental health at Extern. Are you on there, Mal?

Mr Mal Byrne (Extern): I am on, thank you.

The Chairperson (Mr Gildernew): Thank you. Mr Iain Cameron is the harm reduction manager with Extern. Do we have you on the line, Iain?

Mr Iain Cameron (Extern): Yes, I am here.

The Chairperson (Mr Gildernew): Thank you for that. I invite you to present. We are first going to Mrs Anne-Marie McClure. Anne-Marie, would you like to go ahead and brief the Committee, please? We will then go to the other members in turn. Please say who is speaking before your presentation.

Mrs McClure: Thank you for the invitation. We are pleased to be offered the opportunity. Thank you, Colm, for reminding us that this is Mental Health Awareness Week. We appreciate that mental health is a challenge in Northern Ireland anyway, but it is even more of a challenge as we move through these very different times.

I am the chief executive of Start 360, which delivers drug, alcohol, mental health and employability services across Northern Ireland to young people and to offenders in both community and prison settings. I am chairperson of the Northern Ireland Drug and Alcohol Alliance (NIADA). Members will have my briefing paper, which lists our membership. Our members, in the main, hold and deliver contracts for the Public Health Agency (PHA) and/or individual trusts or all five trusts to deliver addiction services across Northern Ireland.

NIADA has been funded since 2019 by the PHA to allow us to employ a part-time support officer. NIADA, however, is moving forward. Dependent on their income, we ask members for membership fees, which is part of our transition into full independence. NIADA wants to be the independent voice of the sector for not only the providers of alcohol and drug services but service users, who, obviously, are very key to all that we do.

The brief highlights members' concerns across all services as well as the concerns of service users, whom we consulted. It also highlights that NIADA is undertaking two pieces of research. The first piece, which will be produced in draft form on 15 June, is about drug and alcohol polydrug use in the workplace. It has some rich data. It has highlighted some of the concerns that we had about that being a substantial problem. The other research was started just last week, and it is documenting the changes, behaviours and trends among NIADA providers and service users as a result of the pandemic. Hopefully, we will also be able to look at the models of intervention and at what has worked best for those individuals during this challenging time.

I will focus on one thing. We had our last meeting on 29 April, where we raised these issues. One of the issues that were specifically a concern was opioid substitution therapy (OST) services across the five trusts and the lack of clarity and information that we had about that essential service, particularly for new inductions. We felt that there was a bit of a postcode lottery. We wrote to the Minister and the Chief Medical Officer (CMO) about our concerns, in particular about those on the waiting list for induction, those who required induction or those released either early from prison or as part of their natural release into the community. I have to say that we received a comprehensive response that clarified the currently available OST support, but our primary concerns about those outside the service were not fully addressed. I am talking again about the new inductions.

Basically, we are keen that the postcode lottery that exists, particularly in that service, does not continue. A joined-up approach is required so that all trusts deliver services to what is a small number — it is not a high number — of significant high-risk clients. We in NIADA believe that lack of access to those services has a range of knock-on effects that are among those that we have listed in our briefing paper.

At this point, I will hand over to my colleague and NIADA member Eoin.

The Chairperson (Mr Gildernew): Before we go to Eoin, can I check with members that everyone has their phone on mute? There is a wee bit of feedback coming through the system. Could everybody check that their phone is on mute and, if not, place it on mute, please?

Mr Ryan: I echo what Anne-Marie said and thank you for the opportunity to present to the Committee. I work for the Simon Community, and I manage the drug and alcohol services in the organisation. I will give you an overview of what we have been experiencing in our services over the lockdown period.

Initially, drug and alcohol use was relatively stable in that period. There was a significant reduction in our overdoses, which we were initially quite surprised about. That has changed in the past few weeks, particularly in the past three weeks, when we have seen a significant increase in overdoses, especially of street-bought diazepam or "street blues", as they are colloquially known. The hostels are flooded with those pills at the moment. We have had the opportunity to send a number of them away for analysis. They have come back with various substances in them but none with diazepam. We had pills in Newry that were tested and came back with morphine, and there were pills from the Belfast area that came back with flualprazolam, which is a novel benzodiazepine that is more similar to Xanax. We are concerned about the potency of the pills and the fact that our service users are taking them in fairly large amounts. We see quite a lot behaviours like aggression and low mood. There is a significant increase in incidents related to aggression, and we have sometimes been forced to close beds when people have been arrested as a result. The availability of the pills has quite a knock-on impact. As I said, the hostels have been flooded with the pills.

One thing that I will take the opportunity to mention is that, if we were able to have the pills analysed locally and have the information about their content shared, that would have a significant impact for us in getting information out to our service users about the risk and about what is actually in the pills and provide them with some harm reduction advice. We send the pills to a place in Wales called the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) Project to have them analysed, and the process of getting the information back is slow. It seems a significant gap that that is not available to us locally.

We also see a significant deterioration in a lot of service users' mental health. The staff in our hostels are having to step up what they provide support-wise in the absence of a lot of the other services that we rely on, which now provide remote or telephone support. That works for some but is not working for our more chaotic service users. There is no respite for a lot of those individuals. They may have taken days off-site to stay with family or friends, but those avenues are now closed, so they spend considerable time in their rooms in the hostels. Communal areas are obviously difficult for social distancing. The deterioration in mental health is having an impact on substance use. We see an increase in drinking and polydrug use in general and the knock-on impact that that has on overdose.

I echo some of what Anne-Marie said about OST, the opiate substitution therapy. We have worked with a number of individuals to get them to the point where they are ready to be inducted onto OST. However, there are no time frames for when the service may be reintroduced, so their motivation to remain at the stage where they were starting to stabilise has gone. A lot of them have returned to high-risk drug use. Again, the impact of that has sometimes been the loss of beds because of behaviours or being arrested because of what they had to do to get money.

I reiterate that we are in the dark. We are not sure of the time frames, and we cannot then pass them on to our service users, who find it difficult to maintain or sustain any type of stability. We are dealing with that at the hard edge. We call for better communication with the substitute prescribing teams and community addiction services. Proper partnership working would help with communication and with the transparency of decisions on what the road map for reintroduction should look like and what is happening in the different regions and trust areas. Simon Community hostels are right across the North, so we see at first hand that services operate differently depending on where they are.

I know that our time is limited, so I will finish on that point. Thanks again for the opportunity.

The Chairperson (Mr Gildernew): Thank you, Eoin. Is there another member of the panel who wishes to present now?

Mr Byrne: Thanks very much for the opportunity to discuss what has been happening with our services and beyond. Extern provides about nine drug and alcohol services across three trusts, mainly working with chronic and severe drug and alcohol users. I echo what Eoin and Anne-Marie said: there have been a lot of difficulties in adapting our practice, but I think that, overall, we have done the best that we can.

We have five specific services in Belfast, and they have kept working throughout this period. Obviously, working face to face on the street is difficult. Some of our other services are outreach services, and providers would traditionally have gone into the home to work with individuals with chronic alcohol and drug issues. That has not been possible. One of the new ways of working — the "new normal" that people talk about — involves a lot of phone contact and even meeting people in their garden. That has its challenges when you work with people who are chronically using substances.

One of the issues that we face — the other witnesses mentioned this — is a rise in desperation among some service users. We have noted an increase in aggression and a deterioration in mental health, especially amongst individuals who find themselves homeless or have been homeless. From what we can see, there has not really been a reduction in the supply of illicit drugs. What has happened is that getting access to money to purchase the drugs has become more difficult, and that has led to a level of desperation among some service users.

We in Extern have dealt with a number of overdoses on the street in this period. That continues to be an issue. I know that a lot of providers, Extern included, have continued to give out naloxone on a regular basis to ensure that hospitals and other providers have access to it to prevent overdose, if possible. We have also seen a rise in polydrug use. Again, that may be due to the price of drugs and difficulty in getting the funds to buy them. There has been a switch to alcohol and benzodiazepines, as Eoin pointed out. That may be because the money is not available for people to buy heroin or other opiates.

One of the big things that I would like to point out is that some positives have been coming out of this work. We work closely with the councils, the police and other providers, especially those in the homeless sector. The sector has done some excellent work with this client group.

Extern wrote to the CMO about access to substitution therapies. We have put forward a plan for low-dose substitution for 25 to 35 IV drug users in Belfast city centre who expressed to the teams a willingness to move onto it. I know that that has happened in other parts of the UK and Ireland. We got a response from Dr McBride, but it basically directed us back to the trust, so that really has not moved forward. We proposed that we use GP services to stabilise people and move them on to low doses of methadone, which would stabilise a lot of their issues and maybe help with some of the other behaviours. I know that the Housing Executive had moved a lot of people into temporary accommodation — flats etc — and there were a lot of issues with that breaking down. We thought that, if we followed the model in Scotland and some other parts of the UK where people have access to rapid induction stabilisation, maybe we could have worked on some of those issues and prevented drug use, overdose and some of the other behaviours. Unfortunately, that did not happen. Again, not to be too controversial, Northern Ireland seems a wee bit behind in its approach to substitution. I know that the Belfast Trust last week said that it would induct two new people a week. I think that it said that it would be the first trust to do that, but, again, with two people, it will take a long time through get through the cohort who are using.

As regards future issues for people to think about, obviously, everyone is aware of the deterioration in mental health. It is Mental Health Awareness Week. We have seen that deterioration already during this period amongst some of our service users. There will be difficulties with one-to-one engagement, especially therapeutic work. Like all organisations, we are trying to think creatively about how we can do that. Again, in the press today, there was information about how the use of alcohol had increased dramatically and could lead to long-term issues. Obviously, with the cost of what is going on, there will be funding issues for our services in the future. Our community crisis intervention service (CCIS) up in the Foyle area, which deals with people who present with suicidal ideation, will run out of funding in June. That project will probably close soon. The irony of that and other projects that work to prevent suicide is that we probably will face more and more of that, and drug and alcohol use is a key factor in it.

That is really all that I have to say on that. I am aware of the time. Thank you very much for the opportunity.

The Chairperson (Mr Gildernew): Thank you, Mal. Finally, I go to Alex, who, I believe, is giving a presentation on behalf of Addiction NI. Alex, are you there?

Mr Bunting: I am. Thanks very much. I echo the remarks of my colleagues and say thank you for the opportunity to come and present to you today.

I am the director of Addiction NI. As you know, we provide step 2 services for the Public Health Agency and the Belfast Trust. In Belfast, there are significant waiting lists for our step 2 services. Over the past few weeks, we have seen that demand increase. We also operate the substance misuse court in partnership with the Courts and Tribunals Service and the probation service. We have a significant older adults programme in the Western Trust area that focuses on over-50-year-olds who are impacted by alcohol. Since the lockdown, Addiction NI has moved quickly to adjust our delivery model to enable people to receive continued support. Our service schedules remain at capacity. We continue to have significant waiting lists, as I said, for our Belfast services. That is down to a gap in the

commissioning framework that happened about five years ago and was never filled. I will say that alcohol is the primary drug that causes issues for our client group and the people who come through our services, with prescribed medications also causing significant issues.

With regard to our more chaotic profile coming through the courts, I echo some of the concerns and issues that Mal and Eoin raised about access to OST. We need to look at what goes on across the UK and try to mirror some of the best practice to bring us in line and up to date in how we approach that issue. We have seen that 31% increase in alcohol sales through off-sales. That has been reported in the media as well. With regard to referrals for people who are impacted by alcohol misuse in particular, of the 204 people on the waiting list for our Belfast service, 84 are over the age of 50, and their primary drug use is of alcohol. Since lockdown, we have seen older adults being impacted by the use of alcohol. That is probably representative of the increased sales of alcohol as people try to deal with their mental health issues, anxiety and isolation.

We have also seen a significant increase in people accessing our social support services and getting help to access food banks and community support schemes, so we have had to increase our capacity in social support. We have also had to look at different ways of connecting people. Some of our service users do not have access to mobile phones, for example, or have not had money. We have secured some support from local supermarkets, giving us mobile phones to keep people connected during lockdown.

As Mal said, we have seen huge positives and learning experiences through this. Our telephone support and engagement service was able to take over straight away, and we have all been working remotely from home. We have moved all of our recovery groups online, where they are working with great success, and we have enhanced the social support services that have helped people access real things like food parcels and access to other social supports. We have also developed a check-in service to try to prevent people from relapsing and to keep people stable. That is for our service users who may have completed a round of treatment, and we have just kept them engaged, making sure that they are OK during lockdown. We have also developed an online support hub that is being heavily used across workplaces, Sport NI and the veterans community. We plan to launch that further for other age groups and service users in the future.

The Chairperson (Mr Gildernew): Thank you, Alex. That completes the presentations. We will go now to a few questions and answers. Before I start, I should declare an interest in that I previously worked as a social worker and have worked with many of the organisations involved. I was in an older-persons team, but there were significant issues around addictions and co-morbidities and issues that you have already identified. In my experience, the service that you provide to us, as social workers, was invaluable, but, unfortunately, often there was not the capacity for many cases.

The Department of Health has advised the Committee that robust procedures have been put in place to ensure continuity of services via telephone, video and online systems. In particular, measures have been put in place to support those on substitute prescribing, and naloxone and needle exchange services remain fully open and operational. Several of you have mentioned the opioid substitution treatments as a particular difficulty, although there has been some good work there. In general, have services, in your view, remained fully operational, and how effective have the trusts and the PHA responses been to date?

Mrs McClure: I will take that question. I speak on behalf of Start 360 but also more generally from a NIADA perspective. We have had really good support from the PHA and are working closely with it as we transition our services from face-to-face to remote engagement. The PHA has also extended our funding to December 2021. Most of our contracts around drug and alcohol services were due for re-procurement and, as a result, those contracts have been extended, which has given us and our staff some comfort.

Again, from a Start 360 perspective, our contracts with the trusts have continued as well. Some of our staff continue to deliver face-to-face. Across the Prison Service, that contract is delivered by the South Eastern Health and Social Care Trust, and our staff have been redeployed in the prisons to work as part of the trust surge plan. We are not, at this point, delivering the services that we were contracted to, although we are doing our usual committal work and meetings with prisoners who are soon to be released. In the main, our services are being delivered through the primary health care surge plan, and the mental health team in prisons is very busy.

In the community, our contract is with the trust. Again, we have had great support there. We are part of its surge plans, and some of our staff have now been redeployed into children's homes to deliver on

those plans. As the rest of the NIADA members highlighted, one of the big positives to come out of this, certainly from a Start360 point of view, has been the joint working approach, partnership and collaboration between the trust, the PHA and us. What we note personally is the opportunity for almost immediate access around any concerns or worries. We are in regular contact with the PHA and our trust funders.

The Chairperson (Mr Gildernew): OK. Thank you, Anne-Marie. Can you please stay a wee bit back from your microphone? There is a bit of feedback on your line. We often ask members to keep close to the microphone, but, in this case, stay slightly back.

Mrs McClure: OK. I will do.

The Chairperson (Mr Gildernew): Thank you for that response. There are some good positives in there. In its open letter to 'The Times', the Transform Drug Policy Foundation has called urgently for more funding. However, the Department advised the Committee previously that services during the COVID-19 pandemic must be managed within existing resources, albeit with some reconfiguring as required. In the panel's view, are services sufficiently resourced to cope? Are there additional pressures on the services specifically at this time, as a result of the pandemic? Which of you would like to lead on that one?

Mr Bunting: I will speak from my experience of our services in Belfast. As I have highlighted, there was a gap in the commissioning framework for Belfast services. Over the past four or five years, it has received significantly less from the Public Health Agency for the step 2 services. When the commissioning was taking place, obviously, the Forum for Action on Substance Abuse/Suicide Awareness (FASA) was a huge part of the drug and alcohol arena in Belfast. With that gone, there were no replacement funding or services recommissioned to fill that gap. Addiction NI has been operating a service that is oversubscribed but does not have the capacity to deal with the numbers of service users coming forward or being referred from professionals. We have had additional support from the Public Health Agency, but it is restricted in the support that it can give us in terms of uplift. So there is an issue in Belfast around the step 2 services. Since the pandemic began, we have seen, as outlined, an increase in alcohol use. Professional referrals are increasing, and a significant waiting list has developed. That is just one issue for us.

The other issue is that we have a huge programme in the Western Trust area that has been lottery funded for the past five years, called "Drink Wise, Age Well". It is a hugely resourced programme, well researched and backed up by evidence in its delivery. That has received a six-month extension until September, but it will then cease. That is an older folks' programme that supports around 115 people per week, and that will go. Addiction NI has significant concerns about the amount of service required to address the referrals that we receive and the ending of the funding that the lottery has put in, which the commissioning framework has not been in line to pick up.

Mrs McClure: I would echo all that Alex has said. There are gaps in services, particularly those that the lottery had been funding on the impact of alcohol. Start 360 had been delivering through-care provision for prisoners coming out, particularly those with alcohol problems, and that provision was extended to deal with drug use. The outcomes were extremely positive, not only for drugs and alcohol but on desisting from offending behaviour. After five years of support, although there was an appetite for and a recognition of the work that was done by way of that through-care provision, which supported prisoners of all ages leaving prison with addiction issues and put an intensive programme around them for up to six months post release, as was the case for all lottery-funded impact-of-alcohol provision, very little of it was mainstreamed, leaving a massive gap in provision.

The Chairperson (Mr Gildernew): OK, thank you, Anne-Marie. I have engaged with Drink Wise, Age Well, which has done terrific work across the Western Trust area.

Mr Byrne: I wanted to flag up that, traditionally, in the history of opiate use — heroin use, in particular — there has been a surge in use when there is a recession. When we come out of this situation, there could be another growth in the use of heroin in our major cities. We have seen massive growth in the use of drugs and IV drug use in the last few years. I wanted to put a marker down that we could have more issues with heroin. Access to treatment will be even more important. Extern has had great support from the PHA, but, to be honest, the trusts have not shared a lot of communication, especially on work with IV drug users. That is something that we would like to flag up. We need to learn from other models in Europe and further afield how they deal with the issue, because it will not go away.

The Chairperson (Mr Gildernew): Thank you, panel. I now turn to our members who are on the phone. Members ringing in has allowed us to maintain social distancing and keep meetings going throughout, but they are at a bit of a disadvantage. I will go to the members on the phone first and then to members in the room.

Órlaithí, are you on the line?

Ms Flynn: Yes, thank you, Chair.

The Chairperson (Mr Gildernew): I remind members that they will have two quick questions and, perhaps, another, if we get additional time. However, we have another session. We will go with two questions in this round. Go ahead, Órlaithí.

Ms Flynn: Most of the core issues that I wanted to address concerned the opioid substitution therapy, homelessness and alcohol. It was interesting that you have already addressed those issues in each of the presentations. It is good to hear about the PHA and what Anne-Marie had to say about the flexibility of contracts. We have had good feedback in some of the suicide prevention groups. It is important that you have that flexibility, because you will face additional pressures. I am conscious that all three trust inpatient units have closed, as have Northlands and Carlisle House. You face additional pressures in dealing with what you work with, so well done for all the work that you have been doing.

A few of the panel mentioned a return to high-risk drug use and a rise in polydrug use. Given some of the comparisons with death by suicide, are you picking up on a rise or reduction in the number of drug deaths? I know that, in Belfast, some of the averages are down. That is not to say that we do not know what is ahead of us, but do you have any sense of the number of death? Do you have any information on that?

Secondly, the issues around alcohol are massive. They came up at the all-party group on suicide prevention the other day. Of course, that is a longer-term issue that we will have to deal with. Without a doubt, there has been increased alcohol consumption, probably right across society, since the lockdown. The Public Health Agency has said that it is working on messages on that issue, but do you think that they are enough? What else could we do? It will affect so many homes, and there will be so many repercussions, such as domestic violence and mental ill health. What more could we do, even in the short to medium term?

Someone mentioned the crisis de-escalation centre in Derry. We have a meeting about that later in the week so, again, that has been flagged up as a concern. Alex mentioned the commissioning gap in Belfast: that is what we need to focus on for the new strategy. We have the pre-consultation in June, so we need to make sure that we clear up any gaps now so that you are in a good place to deal with any increased need.

Mrs McClure: I do not have the number of suicides related to drugs and alcohol at hand, but it is my understanding that, recently, one death occurred 24 hours post release as a result of an overdose. Naloxone was used, but, unfortunately, the person did not survive. In Start 360, we have seen an increase in suicidal ideation and crisis situations. Again, we have been working with the police in some of those instances where young people have activated their end-of-life plan. Thankfully, as a result of good collaborative working, those plans were stopped, and we are working with those individuals more intensively.

It is difficult to engage remotely. Working with families where there is deprivation and disadvantage and doing so confidentially is extremely difficult. We mentioned in our briefing paper — Alex has already introduced it — that the big issue is that alcohol consumption in the general population is definitely increasing. We know that from the amount of alcohol being sold. If it has increased in the general population, it has definitely increased among those who are more vulnerable. The issue for us in engaging is not just the lack of digital capacity but access. Many of our clients have smartphones but do not have the internet. They would have used the internet in shopping centres, libraries, McDonalds or Kentucky Fried Chicken, but they no longer have that access. Getting the messages to the general population is so much easier than getting it to those who are most impacted.

The COVID-19 situation is magnified in the groups that NIADA and our members serve. They are some of the most complex and chaotic individuals in our society, and it is about getting messages to them. Do not get me wrong: we are doing wonderful things working remotely as best we can, and some of that has to be at the garden gate or the front door for some of our clients, but, as

organisations we, too, have to support and protect our key, front-line workers. There definitely need to be more conversations about how we do that and do it better.

Mr I Cameron: A couple of points were made about OST. Mal spoke about the potential increase in heroin use coming out of COVID-19. I operate and manage projects in Belfast, including the street injectors support service, which is an outreach service that provides needle exchange and support to those who street-inject, and our dual diagnosis service, which provides a service to those who have severe, enduring mental health issues, homelessness and drug and/or alcohol problems.

We have noticed an increase in people's mental health presentation; in fact, our dual diagnosis team was called in by PSNI negotiators two weeks ago. One of our clients had climbed a crane in the city centre and was going to end his life, but brilliant cooperation between the PSNI and us ultimately saved that guy's life. His backstory is one of opiate dependence. During the COVID-19 period, we have identified that, on the ground, there are approximately 25 to 35 individuals who are opiate-dependent and would benefit greatly from opiate substitution therapy. We work with the PSNI and have done so throughout this. Many of those clients were being issued with fines on the street. Many of them have been homeless, but, through the great work of the Housing Executive, they have been given premises. They were routinely breaking the COVID-19 restrictions because they had to come out to access opiates, other drugs and money. As Mal said, we made representations to Michael McBride in relation to that. At that point, substitution therapies had been stopped throughout Northern Ireland. Mal correctly said that the Belfast Trust has now picked up on that and is to start inducting new clients.

I also have a concern that, as the lockdown ceases, people's risk of overdose will increase. During COVID-19, people's tolerance to drugs, particularly opiates, will have reduced. When their drug use is then reinstated or increased, there is the potential for a dramatic increase of overdose deaths in the city. We propose that, as in other parts of the UK and Ireland, low-dose prescribing is introduced at this time. That would get people engaged in treatment and prevent the chance of overdose on the other side of this.

I echo what others have said in that we, too, have had great support from the Public Health Agency and Belfast City Council through the police and community safety partnerships. Both those organisations have supported us financially to keep our services, including our face-to-face services, running throughout the pandemic. There is great work being done, but there are other things that we could do. The Belfast Trust and other trusts need to be resourced to look at some of this now and into the future.

Mr Easton: I thank the panel for the presentations and for the vital work that they do in the community. I have two quick questions. The first is to Alex. You mentioned an increase in referrals during this period. Do the organisations on the panel have the resources to cope with that increase? What are your resource gaps? My second question might be for Ian. You mentioned that various drugs have to be sent off to Wales to find out their content, which I found interesting. I am disappointed to hear that you cannot do that in Northern Ireland so that (a) you get a quicker response, (b) you can get the information out there to help those who are addicted not to take those types of drugs and (c) to deter suppliers to an extent. Have you been in contact with anyone from the PSNI or the Health Department about that? Have you had any help towards trying to get drug assessment set up in Northern Ireland so that you can get that information more quickly?

The Chairperson (Mr Gildernew): Thank you, Alex. I will go across to the panel. Alex's first question is on resource gaps, the second is on testing. Which of the panel would like to start?

Mr Bunting: I can answer Alex's first question. It is a bit of a problem for us, because the gap was there prior to the pandemic coming on top of it. The issue for us is that our treatment plans and referral rates do not match, so a waiting list develops. We did not have enough resources to address the referrals as they were. We have seen an increase in referrals from professionals but a slowdown in other referrals, particularly self-referrals. People are not referring themselves to the services, but they are coming to us via professionals or the trusts. Much good work is being done through our partnerships with, for example, the Belfast Trust and its referral hub. We are trying to address things as best we can.

We are also, Alex, seeing added social needs of our clients, which is resource-intensive. We are trying to link clients with local resources to keep them connected. We also see increased social isolation among a group that was already isolated in the community. That adds another layer of support and

resource. It is not that that was not required in the past, but it was very treatment-focused. We now see greater exposure of the social needs of our clients. For example, we just talked a lot about older adults. Older adults who maybe previously sat in bars, had a few pints and went home now bring crates of beer into their house and drink them there. That causes all sorts of other issues in the home, and we are getting increasing numbers of calls from family members. One of the things that we have been doing in the last week is working with Volunteer Now on the creation of an alcohol helpline. We are looking at volunteer, induction and training roles so that we can bring suitably qualified people in to volunteer on an alcohol helpline. That is one of the things that we are doing to try to address some of the concerns and issues, including those of family members.

We face challenges. There is no doubt that, coming out of this, we will face challenges across alcohol and drugs. I echo what Ian and Mal said about the injecting drug population: increased support could be required as we come out of lockdown.

Mr I Cameron: It was Eoin Ryan who spoke about testing initially. If he does not mind, I will answer some of the question, and he can come in on the back of that.

Mr Easton: Yes, super.

Mr I Cameron: Our only access to testing at the minute is through a programme in Wales called the WEDINOS Project. How that operates is that, if we receive an unknown substance, we package it into an envelope, it is given a code, it is posted off to a lab in Wales where it is tested, and then we receive the results via a web link. Of course, it takes considerable time for that to happen. Extern and NIADA have spoken with the PSNI, the Public Health Agency and others about having access to that type of testing in Northern Ireland. The PSNI is already under pressure through having to send off the drugs that they seize to be tested for criminal cases. It is already at its maximum capacity — over it, in fact — for testing for substances. The PSNI does not have that ability if the test is not in relation to a criminal case.

When it comes to accessing testing from somewhere else, the equipment required is a mass spectrometer, which, as, I am sure, you will appreciate, is extremely expensive. The trusts and the Public Health Agency have looked at that, but the finance is not there. My only suggestion on that is that we could, possibly, have a discussion with the Welsh project to see whether we could buy in extra spots for testing. Their system is set up for their needs, and it is through goodwill that we have negotiated that pathway. However, there might be some way that we could look at providing help and support for the costing of their project to give us more access, if that makes sense.

Mr Ryan: I will expand on what Ian said about testing. The value of testing is that we have been able to get accurate information about the content of what people are taking and relay that back to the users, so it has had an impact on their ability to act on the harm reduction advice. As well as that, it would enable us to have timely information on the cause of death. Sadly, we had a death in one of our Belfast hostels last week, and it appears to have been drug-related, although it is unconfirmed. Blues — diazepam — were found in the young man's room, so there is a fairly direct link.

Without testing, we do not get information about the confirmed cause of death, and that is an issue for a lot of the other services. We need to be able to get that information out in a timely manner and pass it on to our service users. We can see the direct impact of that already. We have been able to send samples off to WEDINOS and get that information back and provide it directly to service users.

The Chairperson (Mr Gildernew): Thank you, Eoin and Alex. We will go to our final member on the phone. Are you there, Pat?

Mr Sheehan: Yes, Chair, thanks. I want to highlight a couple of the number of positive things that have been said. There is greater collaboration with the trusts and the PHA, which, in the current context, is excellent news. When the crisis ends, that collaboration should continue. If it does not, it should be flagged up to us as politicians as soon as possible.

The other thing that I am glad to hear about is the setting up of the alcohol helpline, which will be needed even after this crisis finishes. We all know that the sale of alcohol has increased, and there are many reasons for people increasing their drink intake at this time, whether it be anxiety, isolation or whatever. Some more mundane reasons include people working from home or not rushing to get the kids out to school in the morning. Previously, they might not have opened a bottle of wine on a Tuesday or Wednesday. Now, however, they say, "Well, there is no rush in the morning, so let us

enjoy ourselves". Others are saying, "God knows what will happen in this crisis, so we might as well enjoy ourselves". Anyway, those are just observations.

Anne-Marie made the negative observation that many vulnerable people have smartphones but not the internet. Contact tracing is beginning, and that could be a difficulty, if we are to use the phone apps that have been much talked about. If this is a vulnerable group who might not pay as much heed to social distancing as others, we would have to that keep in mind.

I have two quick questions. No one has mentioned gambling. Has anyone evidence, anecdotal or otherwise, of an increase in gambling in this period? I imagine that people who usually get their thrills from football matches, motorbike racing, mountaineering or whatever might be bored and getting a kick out of online gambling. As lockdown eases, do we expect major problems as a result of home drinking?

The Chairperson (Mr Gildernew): Who in the panel wants to pick up on those issues?

Mr Bunting: I will touch on gambling. We are part of the Inspire group. Addiction NI ran a campaign, about three weeks ago, highlighting the impact of and risks associated with gambling. We did some work with Oisín McConville on that. Our biggest concern was the increased investment from betting companies and how they were able to target people during lockdown. Day and night, TV screens are showing advertisements for bingo or betting apps. Those betting firms have increased their marketing budgets to target people during this period. Can something be done to restrict that? They are trying to exploit vulnerable people at a time when they are especially vulnerable. No doubt, when we come out of this and look back, we will definitely see increases in online gambling and the use of online gambling apps. Those firms have invested heavily in that marketing strategy, so it is a concern.

You also asked about lockdown and alcohol. People are developing a habit that will need treatment in the medium term, and we need to prepare for that.

Equally, we need to look at what the long-term impact of COVID-19 will be on the region. We need to consider short-term and long-term plans to address mental health needs in Northern Ireland. We need to bear in mind that our mental health service receives between 5% and 6% of our health budget. By comparison, 13% of the health budget in England is directed towards mental health services. We need to think about how we fund mental health in this country. That would be a good starting point for any Executive needing to make huge decisions on our health spend.

Mrs McClure: I echo and support everything that Alex has said. One of our members, Dunlewey Addiction Services, delivers gambling addiction services. Certainly, the feedback is that their services continue to support gamblers. One of the biggest issues is exploitation. If you are interested in more information, I can ask the director, Pauline Campbell, to update you.

Mr Sheehan: Thanks for that, Anne-Marie.

The Chairperson (Mr Gildernew): That touches on an issue that the Committee has explored before, which is the funding of mental health services. It is certainly a concern.
I will ask the members in the room for their questions.

Mrs Cameron: Thank you to the panel. I put on record my thanks to those who continue to work with those with an addiction in our communities during the public health crisis. It is very welcome. Thank you. I have two questions. I do not think that anyone has yet mentioned personal protective equipment (PPE) or the potential need for PPE for staff and volunteers. I think especially of what will happen as restrictions start to ease. Obviously, we have the scenario, which we raised previously in Committee, of social workers and their requirements. I cannot see why the like of your volunteers and staff will not have similar needs as your work progresses, the lockdown restrictions ease and you have face-to-face contact again. I would like your comments on that.

Eoin mentioned overdoses and said that they had decreased and then increased. Obviously, there has been a gap in time. There is also the question of what is included in the drugs that are appearing. Is work ongoing with the like of the PSNI on tracking down the production and creation of those, what I call, fake drugs, which are so dangerous? Are you working with the PSNI on those issues?

Mr I Cameron: I will pick up on what Pam said about working with the PSNI on fake drugs and glues, for instance. Eoin highlighted, and I spoke about, the WEDINOS project. We have worked out a

system with Belfast City Beat and the PSNI in the city centre. If our workers are out and about and find drugs, we send those drugs to the WEDINOS project and, as Eoin highlighted, invaluable information on those drugs comes back.

Pam, I am sure you are aware of the Drug and Alcohol Monitoring and Information System (DAMIS). Any information that we get in relation to fake drugs, drugs of varying impurity, risks or issues is highlighted through the DAMIS system. The PSNI is working alongside us to update that system. We try to make service users aware of the dangers of some of the fake drugs and the stuff that is out there. We work with the PSNI on a daily basis on a lot of these issues. There is a Belfast city centre tasking group, which is actually meeting now; I am usually at it, but a colleague is covering for me. A number of groups, including the PSNI, the PCSPs, Belfast City Council, Extern, the Welcome Organisation and various others from Belfast City Council meet weekly to talk about those issues, and more. That has been happening for the past two years. The cooperation at that level is amazing. If someone had suggested to me two years ago that we would have that level of contact, I would have said that it would be impossible, but the partnership working with my projects and in relation to the city centre is fantastic.

Mrs McClure: It is difficult to hear to you all, so I hope that I am getting the right end of the stick. NIADA has regular meetings with Neil McGuinness from Grosvenor Road PSNI. The level of communication, information sharing and moving forward in such a collaborative way that has taken place since he came into post has been amazing. To be fair, that had commenced well in advance of COVID.

On the first question about PPE, I can speak only for our staff. The trusts have been providing PPE, scrubs and anything else that is necessary to our front-line staff. Our organisation has developed its own action plan in alignment with the five-step approach. I have heard it from all my colleagues this morning, but what we would like is for our staff to be out there, delivering face to face and doing what we can. However, we also have to apply the restrictions and regulations from the Executive. One thing that is missing from our action plan is a time frame. Within that, our organisation is looking to purchase PPE and make the necessary adjustments to our workplaces.

Mr Ryan: May I just come in on that? Our staff in the hostels have continued to provide face-to-face services the whole way through the pandemic. That is a crucial issue, particularly with the increase in overdose, where it is impossible to social distance when you are trying to save someone's life or when you are administering Naloxone. That is a real concern for us. Thankfully, we have a partnership with the trust, which has been coordinating the provision of PPE. There was a deadline for that, up to 15 May, and the trust has agreed to extend that for a period, but we are not sure for how long. We are waiting to hear from the Department for Communities about what alternative arrangements will be made. Again, it is about the confidence of our staff to be able to continue to provide that crucial service. They need to be adequately equipped, and up to now, in fairness, the trust has managed that pretty well, but we have concerns as the crisis has continued.

Mrs McClure: When I was looking at the cost of masks, the cheapest ones, if they are bought in bulk, are 78p. Most providers are asking for £1 a mask. That is quite expensive, and I am sure that if we work in a collaborative way to source PPE through trusts, it would be much cheaper.

The Chairperson (Mr Gildernew): Thank you; that is a useful suggestion. I want to express my appreciation to the panel, who are now running significantly over time. We have an additional presentation coming up. That is an indication of the level of concern and the wide range of issues that have arisen. I said that two questions was a suggestion rather than a target. If members have a key question, we will try to get round them all.

Ms Bradshaw: Good morning, panel. I have two very quick questions. A few months ago, I heard about the Public Health Agency's pilot of the Naloxone nasal spray. Is that continuing during the lockdown and would it be useful to the Simon Community and other hostel providers?

I asked a question in the Assembly a couple of months back about the waiting list for opiate substitution therapy, and the figures that I received were startling even then. In Belfast, for example, 41 people were waiting to get on the programme. What is your understanding of the size of the waiting list now?

Mr I Cameron: To be honest, we have no idea about how long the waiting list will take. I can only work with the anecdotal information that I have on the ground from the numbers of people that we are

working with. As I said earlier, we have identified roughly 30 to 35 people who were either street homeless or in and out of the hostel system. That is nowhere near the number of people who are outside of that and who need treatment. The Belfast Trust is talking about inducting two people a week. If you have 30 people, that will extend into months. The waiting list continues to grow, and that will just continue after COVID.

Mr Ryan: We had an initial discussion around the Naloxone nasal spray pilot, and then, COVID-19 happened, so it has been postponed. We are waiting to hear about time frames. In conversation recently, I was told that it will definitely happen, but the time frames have been pushed back as a result of the crisis that we are going through. So, I am not sure how soon that can happen. It has not happened yet, but it is on the agenda and will happen pretty soon.

Mr Carroll: I have heard it said that addiction is not an equal opportunity disorder. It can affect anybody, but it affects people in deprived areas more acutely. Alex alluded to a body of research about addiction being higher amongst people who are unemployed. I assume that it is something similar here. Mal referred to the likelihood or possible certainty of a deep recession. Some reports are saying that it will be the worst in 300 years. For notification, in the 1929 US Depression, the suicide rates increased by 50% in one year, so, potentially, we are looking at a massive spike. I am concerned that we do not have enough funding as it is for those services. Does the panel think that we need some kind of emergency injection of cash into mental health services to deal with the likely spike in referrals that will probably come at the end of this crisis?

Mr Byrne: Alex alluded to the underfunding of mental health services, and I agree with everything that Gerry said. Most of us, as providers, have seen the increase in suicidal ideation — low mood and anxiety — and you are right: we are going to face many more problems as we move through the lockdown easing and then, hopefully, at the end of that, into whatever the new normal is.

We could get ahead of the curve and look at how we fund that at various levels, from education and awareness to actual response. You are right: traditionally, alcohol and drugs will become even bigger problems, and that will lead to more mental health problems. There is no doubt that we will face a prolonged spike in access to treatment. In Extern, we already have a significant waiting list, which a lot of the other providers alluded to earlier. That is the nature of things. We have always had waiting lists, but it will be even harder. I will let Alex take that up, but I think that we should look at some pragmatic approaches to mental health and try to lessen the impact of this in the end.

Mr Bunting: I agree with what Mal says. Gerry, it is back to the whole thing that we have all the evidence there. If you look at the work that Marmot did around health inequalities, he said that health inequalities track social inequalities. There is absolutely no doubt when you look at the statistics of Northern Ireland that those most impacted by social inequalities suffer greater impact from health inequalities, and that includes addiction. That is across the board and includes suicidal ideation and the impact of suicide. We really need to consider the impact that this will have. It is not that we do not have communities that have already come through significant issues in the past that will, again, layer on top of the trauma that we are going through now. They will be disproportionately hit as a result of that.

Mrs McClure: Gerry, we have collected a wealth of evidence over the years. Many of the Bamford report's recommendations did not move forward. We had a future search in Belfast in which drugs and alcohol and the knock-on effect on mental health were considered. Upwards of 20 recommendations were made, none of which has been implemented.

Mr Chambers: Is it inevitable that there will be a huge increase in demand for all the mental-health support services as we start to come out of the pandemic and, indeed, in the early months of the new normal, as a direct consequence of the crisis and the impact that it has had on society?

I realise that you are not qualified to give me a definitive answer, but do any members of the panel have a sense that sales of illegal drugs on the street have been disturbed by the lockdown?

Mrs McClure: I am awfully sorry; I did not catch anything that Alan said.

The Chairperson (Mr Gildernew): Alan's first question was whether increased demand for the services that you all provide is inevitable. His second was whether there was any evidence that the

supply of drugs on the street has been disrupted as a result of the pandemic. Is that fair enough, Alan? Did you get that, Anne-Marie?

Mr Bunting: I will answer that, Alan. When we look at this, we definitely see evidence. When we look at SARS, or at what happened in Wuhan, we see that they had to bring in psychological first aid and psychological therapies because of the impact on mental health. We know that people's mental health is affected when the rates of drug use and addiction increase. It is fair to say that we expect an increase in the use of our services. That is something that we need to consider in any action plan. That also needs to be underpinned by how mental-health and addiction services work. A lot of the partnership working during the pandemic between the statutory services and the community and voluntary sector shows that we can do very positive things together. If we can carry that forward, additional resources will be required, but I accept that we are in a very challenging time and that everybody will be competing for resources.

Mr I Cameron: I will answer the question about the disruption of drug activity or availability. Our teams are on the ground, and I was expecting to see a reduction in the availability of heroin, in particular. However, we have not seen that. Heroin seems to be just as available now as it was before the pandemic started. What has changed is people's opportunities, for want of a better term, to access money to buy substances. We have seen that people have not been able to afford to buy heroin and, as Eoin Ryan mentioned earlier, they have turned to other drugs, particularly benzodiazepines, alcohol, pregabalin, and some of the other prescribed medications that we know we already have a problem with.

That would probably explain some of the reasons why there was a drop in overdoses and, then, an increase. As people could not afford heroin, opiate overdoses reduced, but as people started to use alcohol, benzodiazepines, gabapentinoids and heroin — the poly-drug use that we call the "gruesome foursome" — we have seen an increase in overdoses again. That leads us back to the first question, which is whether it is inevitable that we will see greater problems arising. The answer to that is yes. Prior to the pandemic, we were already seeing an increase in our problematic drug use, and, as you have heard from everybody this morning, we are already operating waiting lists, and treatments are difficult to access and to get into, some more than others. However, there is no doubt in my mind that this will impact greatly on all forms of addiction across the board, which will then impact greatly on people's mental health.

The Chairperson (Mr Gildernew): Thank you very much, panel, for your presentation and for your very direct answers. I wish you all well in the important and complex work that you are undertaking, particularly at this uniquely challenging time, in what was an already challenging field. Thank you for presenting today. There are many issues there that we will now be better equipped to consider in the future. It has been very worthwhile. Thank you and all the best for now. Slán libh.