COVID 19 Lockdown Trends in Alcohol in GGC

June/July 2020

Alcohol Harms Group Trends Monitoring Sub Group

Monitoring Report on Trends in Alcohol Use and Service Experiences

Final Report, 31st August 2020

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1. Background

1.1 In May 2020 it was agreed through the Glasgow City Joint Alcohol and Drugs Harm Sub Groups that in order to complement an in-progress piece of work to monitor drugs trends across GGC, a similar piece of work should be undertaken for alcohol. A small working group was set up with key partners to develop various strands of this work that will combine to provide a bigger picture on the alcohol related issues presented by COVID-19 and the associated challenges.

1.2 This strand of the alcohol trends monitoring work has been designed to provide a snapshot and this report summarises work conducted on monitoring the trends in alcohol use and the experience of services during this time. It also sets out the summary of finding and presents areas for further consideration on alcohol use and the experiences of staff in services across GGC. The monitoring period is from 1st June to 31st July 2020 inclusive.

2 Scope of the Work

2.1 Whilst the initial request for the work to be undertaken came from Glasgow City, it was agreed the work would be useful to conduct across GGC. Given the board wide specialist alcohol role of the HI Senior post, it was agreed that this strand of the work would be undertaken by this role.

2.2 Similarly to the drugs work, it was agreed that anecdotal information based on the experiences of those working in services was the most realistic and appropriate way of gathering this information.

3 Process

3.1 A list of key service contacts was compiled using networks of existing groups and structures including Glasgow City ADP and Recovery Hub contacts and members of the GGC Alcohol Care and Treatment Group, including the

PCANOS teams. These contacts were sent a template to provide them with an outline of the information that was being sought so allow them to consider or prepare in advance any relevant information. It was made clear that the services were not being asked to complete this template but that it would be used as a basis for discussion for regular phone calls. All recording and reporting of the information would be conducted on their behalf. Service colleagues were also made aware of the purpose of the work and the likely reporting mechanisms of its findings.

Alcohol Monitoring Template June 2020.

3.2 All HSCPs and locality teams including the PCANOS teams, as well as Acute Liaison have participated on a regular basis with the exception of Inverclyde. Attempts to link with Inverclyde will continue to be pursued as this work continues.

4 Summary of Findings

Service Responses

4.1 In the early stages, some services altered their opening hours to be more responsive to service users and all moved support almost exclusively to telephone and/or video conferencing utilising a range of platforms including WhatsApp, Google Meets, Microsoft Teams, Zoom and Face Time. Face to face appointments were not routinely offered in the early stages and were only carried out on a case by case basis where absolutely necessary. As restrictions have eased and practical arrangements for more staff working from their bases have been implemented, face to face appointments and home visits are on the increase and this has afforded more scope for conducting routine blood tests and offering more home detox. For NHS services, the Attend Anywhere option is becoming more widely used and is forming a core part of the recovery and forward planning for service provision.

4.2 Services adapted staff working routines to reflect government guidelines and have for the most part split staff into rota groups alternating between working at home and working from the service base. To begin with, these rotas took account of staff health needs regarding shielding and were impacted by school and nursery closures. Staff reported adapting well for the most part. Staffing capacity continues to be impacted by rising referrals, changes to practice in light of current guidelines which are regularly subject to review, ongoing absence (COVID or otherwise) and issues with vacancies.

Referrals

4.3 Most services reported that at the beginning, the number of alcohol referrals dipped but has been steadily increasing latterly. Most referrals are from primary care with a rising number of self-referrals and a range of other sources including Acute Liaison Services, AHPs and mental health services. Most services are still seeing a rise in the number of referrals from people who have never been known to them prior to lockdown.

4.4 Most services also reported that they were able to respond to referrals more quickly due to the changes in how services were being delivered, resulting in shorter waiting times overall.

4.5 As referral numbers continue to increase and with limited levels of face to face appointments or home visits, some staff are reporting increasing levels of stress in trying to maintain regular contact with their cases as they are concerned that service users may relapse without high levels of contact. Senior staff are working with their teams to manage this using the RAG system and supporting staff to manage caseloads more effectively.

4.6 The main sources of referral continue to be from Primary Care and escalating numbers are being marked as urgent. There are also rising instances of mental health issues being cited on the referral. At times, the primary referral route into alcohol services has been inappropriate as the main presentation is mental health related so this should have been the initial referral route with links to addictions established as part of the care plan.

4.7 The specialist PCANOS services in Glasgow City are currently seeing a downward trend in referrals, reversing the increased numbers seen in the last few weeks. This is likely linked to the ongoing virtual appointment system being utilised within primary care and the lack of opportunity for PCANOS staff to engage directly with GP Practices to further promote the service and be more visible within the practices. Many practices are still not allowing access to any staff not directly employed by them. In addition, many practices are still not holding regular meetings meaning, limiting the opportunities for PCANOS service promotion and links between staff. Community Links staff are assisting with this but with them being home based at the moment this impact is lessened.

4.8 Self-referrals continue to rise as individual levels of concern for changing drinking patterns and consumption levels increase. At times the referrals are more suited to Tier 2 intervention so work to establish an onward referral to other services continues to be required.

4.9 The development of the ADRS Alcohol Referrals During COVID guidance has been helpful in directing the management of referrals throughout the pandemic.

Medical Interventions, Detox and Protective Medications

4.10 With the majority of service provision moving towards phone/video consultations and only conducting face to face consultations in special circumstances, most had streamlined protective medications prescriptions and were issuing them in 28 day doses. This is still current practice. Some service users are responding very well to the added element of personal responsibility and are thriving with support from family members as well as service staff. Other service users are struggling with the changes in how support available. This is compounded by a significant reduction in pharmacy supervision provision which is varied both across the board area and at a local level.

4.11 Acamprosate prescribing is being utilised more than disulfiram currently as the levels of supervision required for safe use are generally a better fit with current service provision practices.

4.12 The absence of breathalyser monitoring is part of this agenda and is being investigated via the NHS infection control team as well as looking to Police Scotland as an example of how this practice can be adapted to resume safely.

4.13 Contact continues to be made weekly with new and/or more vulnerable service users, moving to fortnightly when they are more settled and it's typically monthly for those who are more stable. Staff are making the contact frequency decisions on a case by case basis using a RAG traffic light triage system. Welfare checks are an ongoing part of the contacts being made, picking up on treatment issues as well as any wider health and social issues.

4.14 Inpatient detox support has been available throughout the pandemic and has been offered where appropriate. This provision is subject to regular review and provision has been increased in recent weeks in line with service recovery planning.

Managed Harm Reduction

4.15 Many service users have not been suited to home detox as either they were deemed as too high risk or did not have family members to provide support with the programme safely. For these service users, they are being supported with a managed harm reduction approach to reducing consumption safely and in a phased way or they are being deferred for

support when it can be tailored more to suit their needs. This harm reduction management approach has seen some very positive outcomes for some whilst for others, it has highlighted that they are not yet ready to change their drinking habits at this time. In these cases it has limited the instances of unsuccessful detox completion.

Mental Health

4.16 Many service users continue to report negative impacts on their mental health linked to the current situation. Increasing levels of anxiety, depression and stress are taking their toll and are contributing to increased consumption levels. Many cited the underlying cause of this as isolation in the early days. More commonly now, the sources of these mental health concerns are linked to easing of lockdown restrictions and the potential for increased risk of exposure to the virus for some. For others it is linked to fears for their longer term employment status beyond the furlough period and into the longer term economic uncertainty.

4.17 Those with more severe and enduring diagnosed mental health conditions, especially personality disorders are reporting more extreme impacts leading to significant relapses for many.

4.18 There have been some instances of increasing levels of chaos for those who were chaotic prior to lockdown. The ongoing situation has compounded this further and is evident in the numbers and severity of relapses.

4.19 In addition, there have been reports of suicidal ideation at times and staff have supported service users and have made appropriate referrals and links for specialist mental health support where needed.

4.20 Conversely, there has been some evidence of service users thriving and reporting that the lack of social distractions and interactions has been positive and has improved their recovery.

Physical Health

4.21 In those service users who were reporting positive impacts, there are improvements in physical health. Conversely, in those who are reporting a range of concerns, issues and negative impacts, there was a marked decrease in overall physical health. This was further compounded by the current lack of pabrinex provision leading to malnourishment and poorer nutritional health for some. As pabrinex provision begins to increase in line with reviewed practice guideline, physical health issues can be managed alongside overall care plan management.

4.22 In the beginning, there was an increasing need to provide food parcels, shopping vouchers and make referrals to the foodbanks across GGC, having

an overall detrimental effect on physical health for many service users and their families. Whilst this is an ongoing need, the instances of this have lessened for alcohol services as the other agencies provide the ongoing monitoring and support here.

4.23 Across GGC, some services are recording increasing cases of older adults, particularly over 70s in some areas, who have additional complex needs and long term conditions which add to the complexity of their case. This requires a multi-disciplinary approach to the care planning and management of their case.

Social Issues

4.24 Isolation and the lack of routine was commonly reported as having an impact on consumption levels and mental health for many immediately after lockdown and for its duration. As previously mentioned in paragraph 4.16, concerns over job security in the long term is adding to this for some service users and this is evident in the referrals coming to services, especially from Primary Care. As lockdown restriction have eased, there have been some reports of service users being anxious about reintegrating into society and this has had an impact on their consumption, mental health and risk of relapse.

4.25 With regards to housing and homelessness issues, there have been some positives in here as with the housing movement work being on hold in the early day of the restrictions, some service users who were at risk of homelessness were given a reprieve in the short term. Conversely, this has meant that for those due to move to new accommodation, this was put on hold. This caused some issues for those recently liberated from prison where it has been necessary to rely on temporary accommodation. As public services begin to reopen more fully, movement in this field has been a positive step forward.

4.26 There have been little or no changes to the number of concerns for child or adult protection or concerns for safety, including gender base violence, since lockdown began. One service has reported making an ASP referral which they reports as highly unusual. Another service has had to consider indirect child protection issues through kinship care but these instances have been infrequent and very limited.

4.27 As previously mentioned in paragraph 4.21, food poverty has been an increasing concern with services receiving more requests for food parcels, shopping vouchers and/or support for a foodbank referral.

4.28 As noted in paragraph 4.15, there are increasing concerns amongst some service users on the longer term safety of their jobs and for those who are furloughed, if their job will still be available for them to return to.

4.29 Digital exclusion, by choice or necessity, has been a factor in how service users have been able to engage with telephone and online support. Whilst some third sector agencies have provided loaned smartphones with PAYG SIM cards to allow phone and data usage, this provision has been limited and short term and may not be a solution to longer digital engagement barriers. To a lesser degree, staff skills development to facilitate working in a different and more digital way has impacted on the provision of services in this manner. This has however, been changing rapidly over the last few months as the digital approach is becoming more embedded into practice and is part of patient and service user expectations of public sector service delivery.

Access, Availability and Buying Habits

4.30 Many service users continued to access their alcohol daily from local shops. As time progressed there were increasing reports of bulk buying from supermarkets to limit shopping trips by some. As lockdown restrictions eased, there was a small swing back towards very local buying habits, thought to be due to the reduced likelihood of having to queue as may be the case in a supermarket. There was some increase in the uptake of local delivery services from convenience stores and/or takeaways/restaurants.

4.31 The vast majority of services did not believe that when on-licenced premised reopened, it would impact too much on their client group as the biggest majority are community based home drinkers. However, there were reports that service users were using premises, particularly local pubs, to ease their isolation which then impacted on their consumption levels, consequently leading to increased instances of relapse for some.

COVID Specific Concerns

4.32 Struggles with isolation due to lockdown had been reported as an issue which had differing impacts on different people in different ways as described above. The general trend appears that isolation can be replaced with rising anxiety as noted in paragraph 4.23.

Poly Drug Use

4.33 There have been reports throughout the time period for this work of increasing use of cocaine with alcohol and some instances of moving from amphetamines as the drug of choice alongside alcohol use to cocaine, due to availability issues with amphetamine locally. There are continuing reports of service users on ORT increasing their alcohol use which is a new pattern not previously reported prior to lockdown. Additionally, there are ongoing reports of increasing cannabis use along with alcohol consumption.

These patterns of substance use are in addition to existing use of street valium and some gabapentin.

Recovery Communities

4.34 As with service provision, recovery services have moved their support to a range of online platforms and this continues to be the case. Those service users who were engaged in recovery communities prior to lockdown have reported high levels of engagement throughout.

4.35 However, for those who are new to services and the associated recovery communities' support, engagement is still very low. This is thought to be based on the online nature of the support being unfamiliar and more anonymous.

4.36 The lack of in-person AA fellowship groups is a particular source of frustration amongst service users as the current restrictions continue. Some AA members are taking the initiative and setting up physically distanced meets within their local communities for contacts they already have. Some recovery services are operating physically distanced Walk and Talk support groups for those who are able to participate in this. Whilst these moves are very welcome, there are still obvious but understandable gaps in the recovery support available at this time.

5 Future Considerations

5.1 On the recommendation of the Glasgow City ADP Alcohol Harms Sub Group, continue this work in a slightly reduced way until at least the end of 2020.

5.2 Consider how services can provide more choice in how support is offered and how to improve access to more technology based contact moving forward. Support for staff to make it work optimally.

5.3 Build on positive responses to increased personal responsibility for service users own care plan management.

5.4 Expedite breathalyser re-introduction when circumstances allow it or consider a viable alternative in the interim period.

5.5 Review the potential for re-instating pharmacy supervision.

5.6 Increase the use of alcohol harm reduction and minimisation approaches to manage consumption for those whose goal is not abstinence. Increase confidence in staff to offer this as a legitimate strand of a wider support package. Consider developing more robust harm reduction guidelines to support this.

5.7 Work with recovery groups to re-instate face to face groups, meetings and activities in line with recently issued Scottish Recovery Consortium guidance.

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