

Citywide Drugs Crisis Campaign



Submission to the Methadone Treatment Protocol Review

June 30th 2010

Introduction

CityWide works to promote and support a community development approach to the drugs problem - this means involving the people who are most affected by the problem in dealing with the problem - drug users, their families and communities.

Citywide provides networks through which local communities can develop coordinated responses to issues of drug policy and services. We work with communities to develop responses to the drugs problem in their area, by providing ongoing support. We support best practice in drug treatment and the development of all protocols that assist in easing and reducing the pain and destruction drug use does to individuals, families and our communities. The promotion of effective engagement between methadone prescribing services and community services is an important element of CityWide's work.

CityWide is clear that methadone has been a very useful element of drug treatment in Ireland. But we are equally clear that it is not a treatment in itself. Methadone should be used as part of an overall care plan for drug users; this intervention should include all other elements required for progression in recovery

Methadone is a powerful drug. It brings powerful changes to individuals, families and to communities. It also brings power to those who prescribe and those who provide services within its treatment. Such power can be a force for good and a force for abuse. Community service providers have experienced both aspects of methadone's power and Citywide encourages all developing this protocol to remember the power dynamic involved with the prescribing of methadone, at all levels.

1. Access to treatment

1.1: Reducing waiting times for access to treatment to within one month of initial assessment has been a priority action in the National Drugs Strategy, 2001-2008 and in the current NDS, 2009 – 2016 (action 32). Despite these priority actions, waiting lists for methadone services continue to exist. In Dublin, Trinity Court frequently reports waiting lists of 4 months and more. Outside Dublin the waiting lists are even greater with recent reports (Irish Examiner, April 27th 2010) of 450 people nationwide on methadone waiting lists - Athlone and Portlaoise, reporting over 100 people waiting for more than seven months; in Drogheda 15 people are on a waiting list for 15 months; in Waterford more than 40 people have been waiting for two years. As a result many people are travelling to avail of services in Dublin which in turn overloads these services.

Opiate users who are motivated to engage with treatment services must be given access to those services within one month irrespective of where they live. Service providers have noted that motivation to seek treatment diminishes with stimulant use (crack cocaine in particular) and clients need to be linked to treatment services while they are still motivated.

It may be that the system is already at capacity. However, there are no guidelines in the current protocol that offer suggestions for what capacity is for a methadone service and what a service should do once it reaches capacity. GPs are given limits to the numbers they are permitted to treat; clinics should be given similar limits so that appropriate treatment may be delivered to clients.

We suggest that guidelines for best practice in relation to numbers attending methadone clinics are included in the protocol so that the NDS can be appropriately completed – with, as a corollary to this point, new services need to be opened where demand exceeds supply.

1.2: Allied to the need for a reduction in waiting times for treatment is the requirement for needle exchange services to be provided. The aim in the National Drugs Strategy is to provide "...an integrated treatment and rehabilitation service that provides drug free and harm reduction approaches for problem substance users; and

to encourage problem substance users to engage with, and avail of, such services” (National drug Strategy, 2009-2016, page 7).

We suggest that the provision of methadone services must include widely available and flexible easily accessible needle exchange equipment, advice and services. To date, for many IV drug users, the MQI exchange is the only service available. This is both counter-productive to the purpose of methadone provision and likely to increase the numbers of more difficult problems including poor injecting practices, HCV and HIV.

2. Coherence and co-ordination of treatment at operational level

2.1: In the main community drug services and projects are not consulted or informed by prescribing GP’s on the care or treatment of their clients. There are a number of notable exceptions where joint working protocols have been developed locally for the care of clients (see appendix). Local protocols on agreed shared care of clients should be implemented in all areas.

Action 32 of the National Drugs Strategy *is to develop a comprehensive integrated national treatment and rehab service for all substance users using a 4-tier model approach.* Multi-disciplinary teams should be developed to operate case management which should include the prescribing GP’s and the projects who work closely and daily with the client in supporting their treatment, detox and rehabilitation.

Case management would allow for prescribing rationale to be discussed; all clients should have a right to have a nominated person (a Service Users Advocate) to be involved in their care plans.

CityWide is cognisant of the fact that GPs are under many constraints arising from medical and employment restrictions regarding inter-agency dialogue about cases. However, should a case management approach be adopted, we believe that GPs and clinic staff will find that the expertise and insight brought to the table by the community sector will add to the effectiveness of the work and reduce overall workload with clients and GPs and their staff net beneficiaries.

2.2: Not all clients need to be seen every week. In Britain the protocol calls for a community team to meet the client every 2 weeks to assess them on a formal basis and discuss progress of their plan and make recommendations for continued dosage. We believe that similar arrangements should and can be contracted here.

2.3: We welcome the announcement by the Drug Treatment Centre Board that two of its nurses have graduated as Nurse Prescribers in Addiction. More nurses should be recruited and their services should be available in community settings across the country, particularly in services outside Dublin. Restrictions on prescribing methadone by these nurses should be re-examined, with their role broadened as much as possible. This in our opinion is a priority action given the reluctance of many GPs to provide methadone treatment.

2.4: Clinical training for participating level 1 & 2 GP's should include training inputs covering the role of community projects in case management and the supports projects can offer to GP's/Clinics. It should also include input from clients about their positive and negative experiences of methadone treatment so that more patient-centred services develop.

2.6: Local and Regional Drug Task Forces should co-ordinate regular meetings with participating GP's and local projects to establish an interface. All participating GPs and projects should be obliged to engage in such meetings with terms of reference negotiated and agreed.

2.7: Community detox protocols were developed between voluntary and statutory services in the North Inner City Drugs Task Force Area. These outline how key workers/case managers with voluntary service could support prescribing doctors in the provision of community based detox for methadone and benzodiazepines. The 18 month review was encouraging with doctors, workers and service users having positive experiences. This initiative should be extended to all task force areas and properly evaluated, becoming a main element of national drug treatment if it proves to be as effective as early outcomes suggest.

3. Dosage & Poly-Drug use

3.1: Services report that many clients are engaged in poly-drug use. When compared to the situation in the mid 1990s (when methadone/physeptone prescribing became more widely available through the then EHB) poly drug use is the norm now. It is no longer unusual for clients to be prescribed methadone while they also use heroin, cocaine, cannabis, alcohol and tablets (prescribed or illegally obtained). Services are particularly concerned about health risks for clients who are prescribed methadone but also engage in hazardous drinking.

CityWide is asking that the new protocol includes directives on best practice when the client is using more than just heroin. It also asks that directives be given for best practice in prescribing methadone to those who are positively engaged with psycho-social programmes - particularly where large doses of methadone may limit the positive impact of individual and group therapies.

3.2: Although Benzodiazepines are seldom the primary drug of choice, they are reported consistently as the second and third most common additional substance used. The Report of the Benzodiazepine Committee issued guidelines for prescribing Benzodiazepines. It is the experience of most projects spoken to by CityWide that these guidelines, in most cases, are not being implemented.

Cross-prescribing of Benzodiazepines continues to occur, often undermining the positive influence of stabilising doses of methadone. Co-ordination mechanisms for such prescribing need to be implemented and, at least, need to be commented upon by the new protocol.

3.3: The impact of reducing methadone as a sanction has to be addressed. Aside from the fact that reducing dosage rapidly can impact on the clients' stability, the stability of their family, local community as well as causing major upset in the projects these clients are engaged, this is an issue of human rights. For no other treatment would the removal of medication be tolerated as an acceptable intervention.

While CityWide agree that nobody should be subject to anti-social, threatening or abusive behaviour by clients, we equally agree that removal of opioid replacement medications should never be used as a punishment for such behaviour.

3.4: Many of the service providers report an unexplained unwillingness on behalf of some prescribing GP's to engage in reducing methadone dosage for clients. This is often despite the fact that this is the client's stated wish. This reduction is often supported by treatment and rehab service providers and would be conducive to supporting the clients care plan.

In some cases, prescribing GPs are reported to have increased the dosage prescribed. Service providers have noticed that as a result, some clients are reducing dosage themselves (by not taking the full amount prescribed) except when they have to go to pharmacies - at which point they take more than they have become used to leading to obvious complications. This is a situation that requires immediate attention.

As noted above (see 2.7), community drugs projects are more than willing and able to assist GPs in navigating through this process. Respect for and engagement with a client's desires regarding their recovery, should be paramount and we feel that a response to this situation should be central to the new protocol.

3.5: Clients incentive to detox is often undermined by fear that if they detox they will not be able to link back in immediately with local services and programmes. Projects know of clients staying on very low dosage in order to allow them to keep access to prescribing services. Given the complexities of methadone detoxification, clients should be allowed, if they relapse within two years, to re-engage with drug services as part of aftercare treatment.

3.6: The MTP should be renamed the Opioid Replacement Treatment Protocol with the range of medication on offer extended to include other drug therapies like Suboxzone and Subutex.

Clear prescribing guidelines should be made widely available to medical and non medical services. For example, trials of Buprenorphine (the active ingredient in Suboxzone) have proven it to be more effective than other drugs for certain populations and may have advantages over methadone for the management of opiate withdrawal.

Room should be created in this protocol for emerging and future pharmaco-therapies that will be of benefit to drug users in at all stages of recovery.

3.7: The practice of collecting samples for urinalysis by observing the client by standing in the cubicle while the client is urinating is degrading and its practice should be discontinued.

Again and again, drugs services talk of the impact of taking urine samples from clients. For clients who have been abused (sexually and otherwise) the practice of observation for urinalysis is damaging to self-esteem and self-efficacy for recovery. While CityWide accepts that knowing the drug status of clients is essential, there are many alternatives tests to determine drug use available (including the use of mouth swabs) and we strongly suggest a phasing out of urinalysis in favour of whichever other chosen method is found to be sufficiently accurate and cost-effective. But the current practice must stop.

3.8 Currently there is no clear appeals process for clients in relation to decisions made by prescribing GPs. This is unfair and contrary to actions 3.1/3.2/3.3 of the National Strategy for Service User Involvement in the Irish Health Service 2008-2013.

“Service users should be able to articulate their views and be listened to in their individual interactions with health care professionals and as key stakeholders where decisions are taken about future health service development. The key for service users is that they get clear feedback and that they feel their contribution has been valued.” (Mary Harney, National Strategy for Service User Involvement in the Irish Health Service 2008-2013, page 4)

An appeals process should be established for all prescribing decisions affecting service users to ensure greater transparency and to address the disempowering impact of unilateral decisions

4. Treatment and Rehabilitation in Prisons

It is acknowledged that depending on the nature of their drug problem that prisoners present with different demands for treatment in the prison setting. This causes inconsistencies in the responses on offer to prisoners presenting with problem drug use in different parts of the country. This geographical variation in treatment provision is, in part, reflective of some variation in treatment provision in the communities/counties in which the prisons are located.

The fact that not all prisons are in a position - or are willing - to provide methadone maintenance treatment is an issue that needs to be addressed within this protocol. We ask that clear guidelines on the benefits and 'how to' regarding the provision of opioid replacement therapies in prison be provided within the protocol.

4.1 To respond to Action 43 of the National Drug Strategy, a working group was established by the IPS to examine how to expand the provision of treatment, rehabilitation and other social services and to develop agreed protocols for seamless provision of treatment services.

The working group was made up of members of the IPS, Community & HSE. This group convened on one occasion only. It needs to be re-convened so that its work can be brought to a speedy conclusion.

We believe that such work can enhance the effectiveness of any new opioid replacement protocol and assist the IPS in implementing delivery of effective drug services to prisoners.

4.2: To ensure that people upon release have full access to thorough care for treatment services, the IPS must make contact with relevant Community Prison Link Workers before any prisoner is released. Again, community workers are a resource that can make drug treatment more effective. Prison Links workers are a support to easing prisoners back into their communities but also assist in the accessing of medical services within the community and thereby impacting on the numbers overdosing post release.

4.3: Treatment services within prisons must be able to initiate methadone treatment for prisoners where a community treatment place is not available upon release. This is particularly important where waiting lists are in operation.

There should be no delay or loss of treatment for a person simply because they leave prison. We have had reports of people being retained in prison after they were due for release because there was no community treatment place available. This practice is totally unacceptable and should not continue.

4.5 The IPS Drug Policy & Strategy Monitoring Group, which was established to consider progress made in the implementation of the Irish Prison Service Drugs Policy, must be reconvened and its work completed within an agreed time frame.

5. Data collection

Data collection systems should be expanded to include the work that community and voluntary services undertake, to ensure that data is captured on care plan reviews, interagency plans, and service user progression.

Summary of Points from Citywide submission:

1. Access to treatment to be improved
2. Guidelines on service capacity for clinics
3. Improved access to flexible harm reduction services to be seen as part of methadone provision
4. Need for consultation and engagement with community drug services
5. Full engagement with case management
6. Stable clients to be seen every second week
7. Further roll-out of nurse-prescribers
8. Changes to GP training
9. Interface between drugs services and GPs supported by local and regional Drugs Task Forces
10. Full implementation of Community Detox Protocol as part of Opioid Treatment Protocols
11. Clear guidelines on prescribing doses for poly-drug users (including alcohol)
12. Clear guidelines on prescribing for drug users engaged in psycho-social treatments
13. Comment from the protocol on prescribing Benzodiazepines with opioid replacement therapies.
14. An end to the practice of the use of reduction in methadone dosage as a sanction for unsociable or violent behaviour
15. Services users should have the right to have a nominated person (a Service Users Advocate) to be involved in their care plans
16. The protocol addresses the issue of the unwillingness of some GPs to engage in reducing dosage when requested by clients

17. Access to methadone services should be easily available for clients up to two years after detoxification should relapse occur
18. Methadone Treatment Protocol to be renamed the Opioid Replacement Therapies Protocol
19. The current practice of collecting samples for urinalysis by observation is degrading and its practice must be discontinued.
20. The development of a clear and fair appeals process in relation to decisions made by prescribers of opioid replacement therapies
21. A wider availability of opioid replacement therapies in prison settings
22. The re-engagement of the working group as established by the IPS in relation to Action 43 of the National Drug Strategy
23. Clear protocol for the care of prisoners on leaving prison in relation to access to ongoing opioid replacement treatment
24. Treatment services within prisons must be able to initiate methadone treatment for prisoners where a community treatment place is not available upon release
25. The reconvening of the IPS Drug Policy & Strategy Monitoring Group
26. Changes to data collection to include care plan data from voluntary and community services

For more information about Citywide see our website: www.citywide.ie

Or contact:

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Appendix 1 – Local Protocol



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Tel: 01 831 4985
Fax: 01 851 2272
Email: drugteam@dyp.ie
Web: www.dyp.ie

Joint Working between HSE & Donnycarney Youth Project

In order to ensure a better quality of care for you longer-term and to help you with your rehabilitation, the HSE and Donnycarney Youth Project (“DYP”) have developed a joint programme that includes treatment and rehabilitation. The combination of a rehabilitation programme alongside a treatment clinic is a unique opportunity for you to address key areas of your life. The rehabilitation team is led by the Manager and Senior Project Worker.

The treatment clinic is the responsibility of the GP, Nurse, Counsellor and General Assistants. The Manager and Senior Project Worker of the Drug Team of DYP attend the clinical team meetings in order to discuss relevant issues for your treatment and care. The clinical team in turn also share information with the DYP staff that may be relevant for your rehabilitation in the project. By signing this form you are agreeing to this joint working on your behalf between the two teams. The information shared may include your clinical care details but these will be kept strictly confidential by the DYP and HSE teams.

Client Name: _____

Address: _____

Key-worker: _____

Client Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____