

Review of the Dublin North City and County Addiction Service

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Report Authorship

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FOREWORD

It is with great pleasure that I welcome the Review of the Dublin North East Addiction Services. Since the establishment of the HSE Addiction Service in North Dublin City and County in the 1980's, little has changed. While the numbers requiring treatment has remained high (3000) this constitutes about 90% of all addiction services clients in the Dublin North East Region, the number of substances both licit and illicit used and abused by individuals has grown.

The development of the National Drug Strategies, the Alcohol Strategy and the Substance Misuse Strategy have all indicated that the nature and prevalence of drug use in communities has increased and that more focus on treatment options are required for a broader cohort.

As General Manager with responsibility for the Addiction Service there was a real need for me to understand more about such an important programme within my catchment area, I also needed to future proof the service as far as is practicable and therefore it was agreed that a review would be a good mechanism to begin a process of positive change where the Addiction Service would be brought up to date and offer further options for treatment and care for a broader range of substance misuse.

It was against this background that the review team of UCL/PIRC were sourced. They have come with a great deal of credibility within the Addiction Services field and are well known for their work in the Maudsley Trust and the NHS NICE guidelines. We were quite fortunate to enlist the services of such professionals and it is clear that we have a report that delivers on our requirements but also augments recommendations echoed elsewhere in how addiction treatments should be administered.

I wish to thank UCL for their work on this report. I am glad that it is not prescriptive as this allows us to shape the future in a way that will be meaningful for both staff and clients. It does however begin the process of change that I believe is much needed. I would also like to thank you all for your role in the consultation process. It has not been an easy road, but as with all programmes of change, if they truly arise out of a shared desire to create a more effective service for the clients we serve, the end goals will be achieved and will be valued. It is however, very much a team effort and we are at the start of a shared journey to change how addiction services will be delivered, not only in the north Dublin Area but ultimately how they can be delivered nationally.

Yours sincerely



Des O'Flynn
General Manager
HSE Dublin North City

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Executive Summary

This is a high level review of the addictions treatment services in the Dublin North City and County area. It should be noted that further work, including a detailed needs assessment, will be required to support the implementation of the recommendations made in this report.

The Dublin North City and County Health Service Executive (HSE) provides and funds an addiction service for the Dublin North City and County area with a population of 579,447 (Dublin City Council, 2008). A number of previous reviews of addictions service have been undertaken but implementation of these has been limited leading to the conclusion that a substantial reconfiguration of services is needed if the service in Dublin North City and County is to make the necessary changes to effectively respond to population needs and emerging national policy. The service itself recognises the need for such change.

This report focuses primarily on the organisation, structure and content of the addiction services funded by North Dublin HSE and to a lesser extent other funders. The report identifies some of the necessary resources, training and support to ensure the effective delivery of addiction services. The report draws extensively on the work of the National Institute for Clinical Excellence (NICE), the National Treatment Agency (NTA) in the United Kingdom and other reports already undertaken for the Dublin North City and County addiction service and national reports. The recommendations in this report draw on the guidelines and service models developed by these agencies. The recommendations are developed as principles to guide the development of the Dublin North City and County Addiction Service.

The review team, led by the Psychological Interventions Research Centre (PIRC) at University College London (UCL), met with representatives of each of the different staff groups currently providing services and service users as part of a consultation and received numerous online submissions from these and other stakeholders. The group also met with voluntary sector representatives who provide addiction services but are not directly funded to do so by the HSE.

The recommendations made in this report are briefly outlined below. They are grouped in to two broad areas; *Service* and *Operational Recommendations*.

Service Recommendations

Recommendation 1: Addiction services should be delivered around clinical care pathways for drugs *and* alcohol with a focus on recovery defined for the purpose of this report as an, individual, 'person centred, person centred journey, enabling people to gain a sense of control over their own problems, the services they receive, and their lives and providing opportunities to participate in wider society' (Strang, 2011).

Recommendation 2: Addiction services should be organised to treat all addictions (including alcohol and stimulants), around multi-disciplinary teams which are locality based. The precise boundaries of the teams should take into account and build on the work done by the existing Drug Treatment Centres (DTCs) and the Drug Task Forces.

Recommendation 3: The addiction service should develop limited specialist resources which are capable of operating across the Dublin North City and County area and which serve primarily to support the effective delivery of services through locality-based teams. Speciality services should include dual diagnosis, pregnancy ,hepatitis C, assisted withdrawal for those who needs are too complex for a community based withdrawal and Children, Young People and Families.

Recommendation 4: Effective clinical leadership is required for the service and this requires the appointment of (a) a clinical director for the addiction service who should jointly chair the senior management team (SMT) and (b) a designated clinical lead for each locality team and all specialist services.

Recommendation 5: Effective management and strategic leadership is required and is fundamental to the delivery of effective care and a service manger should be appointed who should jointly chair the senior management team (SMT). All staff working within the service should have clear lines of accountability.

Recommendation 6: The addiction service should be outcomes focussed (that is, have in place a routine outcome monitoring programme) and the outcomes should link to agreed clinical and service performance measures.

Recommendation 7: A clinical governance structure should be developed to support the work of all clinicians in the addiction service.

Recommendation 8: The comprehensive assessment of need and regular reviews of identified need should be central to the delivery of addiction services in the Dublin North City and County area.

Operational Recommendations

The recommendations below look at the operation and implementation of the service changes and are intended to provide some of the detail to underpin the service recommendations outlined above.

Recommendation 9: All individuals receiving treatment and support from the addiction service should have agreed care plans which should be reviewed and updated regularly, and react to the changing needs of the service user.

Recommendation 10: In addition to individual care plans locality teams should provide a consultation and support service to those individuals with drug and alcohol problems who are treated by primary care services. This can take the form of advice, consultation and training and local service development.

Recommendation 11: All interventions offered by the service should be evidence based and those providing these interventions should have appropriate training and supervision to ensure their effective delivery.

Recommendation 12: Assisted withdrawal (detoxification) services and rehabilitation services should be developed as a part of all care pathways.

Recommendation 13: Service users should be central to the delivery of care with formal structures in place to enable service users to contribute to the design and evaluation of care.

Recommendation 14: A designated implementation manager should be appointed and a steering group established, to implement the recommendations in this report. This group should include HSE management, service users, professionals delivering the service and voluntary sector representatives.

Introduction

This report was commissioned by the North Dublin Health Service Executive (HSE). The purpose of the report is to review the current care and treatment for people misusing opioids, and provide advice on the development of treatment for other substances including stimulants and alcohol.

The increase in heroin misuse in the 1980s resulted in addiction services in Dublin North City and County being largely configured to treat and manage heroin misuse. As such, the addiction service primarily operates a methadone maintenance treatment model with restricted multidisciplinary working, limited case coordination and an inconsistent focus on recovery. National and international drug and alcohol policy, and local trends following an interim substance misuse strategy (Department of Community, Rural and Gaeltacht Affairs, 2009) all point to the need for changes in the addiction service. Local strategy documents also note that the nature of substance misuse in Dublin has changed over the last decade, moving from primarily heroin misuse to include a growing use of stimulants, particularly cocaine, prescription drugs, particularly benzodiazepines, and with many people now using more than one drug (polydrug), along with a long-standing significant level of alcohol misuse. North Dublin HSE was determined to review the effectiveness of current services with a view to improving efficiency and reconfigure the service in line with national policy, local need and to promote a recovery oriented approach as set out in the Strang report (Strang, 2011). The Terms of Reference agreed between the review team and North Dublin HSE can be found in Appendix 2. The report did not undertake any new evidence reviews, drawing instead on existing high quality reviews, primarily from NICE guidance (NICE, 2007, 2007, 2008, 2010, 2010, 2011).

The review group agreed a 'set of principles' which underpin and inform the review and its recommendations. They are set out below:

- Services should be centred on the needs of the individual and based on an assessment of need. The client should be at the centre of the services.
- Primary care is an essential component of the effective delivery of care for people with addictions.
- The treatment of opiate users with methadone should not be time limited. – “Arbitrarily curtailing or limiting the use of OST does not achieve sustainable recovery and is not in the interests of people in treatment or the wider community” (Strang, 2011).
- The effective delivery of care is only possible when robust structures are in place that support an integrated approach to care; including primary; secondary and tertiary health care; social care; the independent sector and the voluntary sector.
- All care and the treatment offered should be based on the best available evidence as should be the structures through which they are provided.
- The service should be able to provide integrated care with access to services that meet identified needs.
- The work of the review group should be within a framework set out in national and local policy documents including the Interim Drug Strategy.
- Care should be monitored at the individual level (through routine outcome monitoring) and at the service level against agreed performance targets.

- The remit of the current addiction service should be extended to provide treatment for those with alcohol and other substance misuse problems.
- There should be robust structures in place which provide for clear lines of clinical and managerial accountability.
- All staff involved in providing treatment and care for drug and alcohol misuse should be aware of and proactively engage with issues relating to the protection of children in line with new Irish Child Protection legislation.

This report primarily considered treatment for adults with substance misuse problems but reference is made to the needs of adolescents. The report considers and makes recommendations concerning dual diagnosis, assisted withdrawal (detoxification) and residential rehabilitation services (including links with a range of specialist providers). However, it should be noted that common mental health problems, such as anxiety and depression, are present in many of those who misuse drugs and alcohol and it is expected that these would be identified as part of a comprehensive needs assessment (NICE, 2011).

Dublin North City and County

The addiction service in Dublin North City and County serves a population of 579,447 according to the 2011 census of population results. This covers the boundaries of the local health districts of Dublin North and Dublin North City and County .

Policy Developments in Ireland

Services in Dublin for addictions have evolved from a service response to the upsurge in opiate use in the early 1980s (Butler, 1991). This increase in opiate use was almost exclusively confined to the Dublin area. A sign of the scale of the rapid escalation in opiate use in this period in Dublin comes from the Bradshaw report which revealed that 10% of those aged 15-24 in the north inner city community that was studied had used heroin at least once in the previous year (Bradshaw, 1983). This led to service provision (initially based on abstinence principles (Butler, 1991) being focussed almost exclusively on the treatment of heroin users. The HIV epidemic in the latter half of the 80s caused a significant shift in focus for drug services in Dublin as they moved towards a harm reduction model and focused on getting more people who were using heroin in to methadone treatment (Butler, 1991). It should be recognised that Ireland has achieved considerable successes in reducing the rate of HIV and drug related mortality.

Methadone maintenance services have remained at the core of Ireland's service provision for addictions, reflected in the 2001 National Drugs Strategy (DH, 2001). Until the publication of the Interim Drug Strategy (2009-2016) there have been limited coordinated responses to the developing needs of other drug and alcohol misusers.

In 2009 the Irish Government decided to include alcohol in a National Substance Misuse Strategy. A steering group was established to advise Ministers on a new strategy. The Substance Misuse Strategy now focuses on alcohol in addition to other substances and should be considered in conjunction with the National Drugs Strategy 2009–2016. This is in line with combining the National Drugs Strategy and the National Substance Misuse Strategy in to a single cohesive strategy. This is reinforced by the National Substance Misuse Steering Group which is clear about the scale of the problem pertaining to alcohol: "*Irish adults drink in a more dangerous way than nearly any other country* (DH, 2012)." The Interim Drug Strategy (Department of Community, Rural and Gaeltacht Affairs, 2009) and the report of the National Substance Misuse Steering Group, highlight the need to reconfigure and rebalance services to be able to address alcohol misuse and developments in drug misuse in Ireland.

The Interim Drug Strategy, emphasising the need for a combined approach to alcohol and drug misuse, sets out five 'interconnected pillars', each with a set of objectives and key performance indicators. These are briefly summarised below:

- Supply Reduction - To significantly reduce the volume of illicit drugs available in Ireland.
- Prevention - To identify and provide interventions for those at risk of developing drug and alcohol problems and promoting greater population awareness of the dangers involved.
- Treatment - To promote access to treatment services and enable service users to benefit from them.
- Rehabilitation - To promote integrated rehabilitation and treatment services that provide both harm reduction and abstinence based approaches.
- Research - To ensure data is available to enable informed decisions supporting policy making and service provision.

This report focuses on three of the five pillars; prevention; treatment; and rehabilitation.

The Brennan Report (DH, 2003), commissioned by the Minister of Finance in 2002 to report on health expenditure within a wider review of public spending, identified a number of concerns about the financial management of the Irish healthcare system which impact on this review and are reflected in changes, both planned and underway, in the North Dublin HSE (see below). The concerns highlighted by the report include: “the absence of unified national management; lack of incentives to effectively manage costs; insufficient evaluation; and inadequate investment in information systems and management” (DH, 2003).

Healthcare Policy and Implications

As already noted, there are changes in strategic management and financial structures at both the national and HSE level which are particularly relevant for this review and the implementation of its recommendations. Some of these changes, which are likely to impact on the addiction service, are outlined below:

- **Cost Reduction** - The health system in Ireland has a cost reduction target of €750m for 2012 in addition to budget reductions of €1.7b over 2010 and 2011 translating to a €4m reduction in the social inclusion budget, currently funding the Dublin North City and County Addiction Service within this financial year. This will require ongoing cost reductions in the addiction service.
- **Public Service Agreement** - This is designed to be a framework by which to “transform, modernise and minimise reductions in health service provision by facilitating a reduction in staff numbers, increasing efficiency and productivity, reducing cost and improving quality.” (HSE, 2012)
- **The development of shared care between primary care and specialist mental health services** - A recent guidance paper (Joint Commissioning Panel for Mental Health, 2012) has outlined the need for better collaboration and integration between primary care and mental health services. This largely focuses on shared care, better communication, training, increased access to psychological therapies and evaluation. In addition it specifically highlights the importance of primary care in the treatment of drug and alcohol misuse and the need for greater clarity of service provision for substance misuse. This provides a good basis and rationale for addressing alcohol and non-opiate misuse problems.
- **Child Protection** - New legislation in Ireland around child protection puts the Children First guidelines on a legal footing and legally requires professionals such as nurses, doctors, counsellors etc to report any suspicions and allegations of abuse to the HSE.

Substance Misuse Policy and Implications

In addition to the broad changes outlined above for the wider healthcare system in Ireland there are also a number of policy initiatives relating directly to the treatment of substance misuse. These include:

- **The likely transition of substance misuse from social inclusion to primary care** - National policy suggests, that as part of a wider move to provide care for people who require specialist services in the community via local Primary Care Teams (PCTs), responsibility for the funding and provision of addiction services may move from the social inclusion service line to primary care line. As a minimum it is expected that PCTs will have a

greater role in the coordination of care for people with substance misuse problems. The coordination of care via PCTs also has implications for mental health in general.

- Quality in Addiction and Drug Services (QuADS) - Enabling statutory and voluntary addiction services to become QuADS (the guiding quality standard framework for addiction services in the Ireland) is noted as a priority for 2012 (HSE, 2012). QuADS provide an opportunity for services to comprehensively audit organisational practice providing a quality assessment framework for drug and alcohol services.
- The Interim Drug Strategy - As previously discussed there are some specific deliverables associated with a greater focus on outcomes, namely, national data collection and the development of a brief outcome monitoring process; and a focus on the use of data from drug testing. An implementation plan to reduce urine testing is also suggested.
- The National Drugs Rehabilitation Implementation Committee (NDRIC) - NDRIC have produced a National Drugs Rehabilitation Framework focusing on integrated care, inter-agency approaches and the development of care pathways. NDRIC have also established a series of pilots to look at the impact of implementing the framework. A number of these are in Dublin North City and County .

The Nature and Epidemiology of Addictions

In Ireland around one in five people used illicit drugs in 2003 (Health Promotion Unit, Department of Health and Children, Ireland, 2004). The Strategic Task Force on Alcohol estimated that Ireland has the second highest per capita alcohol consumption in the European Union (Irish Focal Point, 2011).

In 2003 it was estimated that 14,452 individuals in the Republic of Ireland were using heroin with around 12,000 (83%) of these living in Dublin (NACD, 2005). In 2007 the Central Treatment List, an administrative database to regulate the dispensing of methadone in Ireland, showed 8,291 people were receiving methadone treatment with the vast majority of these in the Dublin area (Corrigan, & O’Gorman, 2007).

Data from the 2002/3 Drug Prevalence survey shows the increasing prevalence of cocaine use, again particularly in the Dublin area (NACD, 2005), potentially leading to an increased demand for treatment. The same survey also highlights the growing problem of poly drug use, for example citing that 86% of those using cocaine were using additional drugs such as alcohol, cannabis and Opioids. Recent papers confirm that at a population level the effects of alcohol are more harmful than that of opioids (Nutt, King, & Phillips, 2010).

There are a large number of health and social problems associated with the misuse of drugs and alcohol other than the dependence itself which may include:

- Physical health problems - e.g. HIV, TB and hepatitis B and C in opiate users and liver disease and cirrhosis in dependent drinkers.
- Mental health problems - e.g. psychosis, depression and anxiety.
- Social difficulties - e.g. unemployment, poverty, poor parenting, intergenerational drug and alcohol dependence and housing problems.
- Criminal Justice problems - e.g. reoffending and criminal record.

Developments in the Treatment of Addictions

There are a range of psychological, social and pharmacological treatment interventions which are effective in the treatment of addictions.

An overarching objective which underpins all approaches is that of promoting recovery. A helpful definition of recovery is provided the Drugs Policy Commission consensus statement on recovery which states that:

“Recovery is a process, characterised by voluntarily maintained control over substance use, leading towards health and well-being and participation in the responsibilities and benefits of society.” (UK Drugs Policy Commission, 2008)

Prevention

Although this is a review of treatment services it is important that a coordinated response is taken towards universal (population), selective (based on sub-populations or groups with identified risk factors and secondary (at risk) prevention regarding drug and alcohol problems. and indicated (some problem/symptom may be present but not the disorder to which they are related). Public health, population based, campaigns (such as those which have targeted smoking) have some success in the area of addictions and school-based selective interventions for children at risk of developing conduct disorder and related drug and alcohol misuse have been successful. The Irish, UK and Scottish governments have also recently proposed or adopted a minimum unit pricing strategy for alcohol, the evidence for which is compelling. Although prevention is outside of the scope of the report; consideration should be given to the use of local needs assessment to inform potential selective and indicative prevention programmes for addiction and related problems in North Dublin

The Delivery of Care

Care planning and case management are two important elements in the effective treatment and care of people with drug and alcohol problems.

Case Coordination

Care planning requires robust assessment and consideration of the following when developing a treatment or management plan:

- Type and pattern of drug/alcohol misuse
- Level of dependence
- Comorbid mental and physical problems
- Assessment or risk assessment
- Service user's aspirations and expectations
- Clarification of the service user's treatment goals

Case management (coordination) should form the core part of treatment for most individuals with long term drug and alcohol problems and usually means that an individual has a specific named worker (often referred to as a case manager or key worker)

who assist the service user to navigate through their care plan and may also provide some of the treatment interventions. Typically this involves the following:

- Establishing and maintaining a collaborative and therapeutic relationship
- Assessment of outcome(s)
- Review and revision with the service user of their treatment goals
- Discussion, implementation, evaluation and revision of the treatment plan(s)
- Liaison and collaboration with other care providers
- Integration of drug focused interventions with other health and social care interventions

Service Structure

The NTA describes treatment for drug and alcohol as a series of phased and layered treatments enabling service users to move seamlessly through a care pathway (NTA, 2006). This approach has been widely adopted for the organisation of services in the UK. Service users should be able to move between the different elements seamlessly depending upon their needs at any given time. This is often represented as a pyramid as shown below in Figure 1 (DH, 2003). However, this is a general model for conceptualising services and not a structure to be imposed on services or individuals regardless of the identified need:

Figure 1: Tiered Care



* Note that this report does not cover tier 4b and it is shown here for illustrative purposes only

Method

The review group membership comprised Professor Stephen Pilling (UCL), Rob Hardy (UCL), Dr Luke Mitcheson (Consultant Clinical Psychologist for Lambeth Addictions South London and the Maudsley NHS Foundation Trust and National Treatment Agency, UK), Dr Mike Kelleher (Consultant Psychiatrist and Clinical Lead for Lambeth Addictions, South London and the Maudsley NHS Foundation Trust and National Treatment Agency, UK) and Dr Chris Ford (recently retired GP, former chair of Substance Misuse Management GPs ((SMMGP)) and clinical lead of primary care network Kilburn, UK).

This report drew on a number of sources of information, the majority of which emerged from the consultation process. The group had initial meetings (see Appendix 3 for full details of all review meetings held) with HSE senior management to establish the scope and terms of reference for the review and met with some key senior stakeholders to establish context. The group then met with representatives of most staff groups, including the voluntary sector, providing the addiction services in Dublin North City and County.

Staff members also made the review group aware of relevant publications and submitted reports and documentation via email. There were a set of questions that were circulated to all staff members and responses were collated and analysed to provide a more detailed picture of current service provision.

The review group held a series of meetings (see Appendix 3) with representatives of each of the staff groups (see the following section for a brief description of their roles) to discuss specific issues. The groups that met with the review team were as follows:

- Psychiatrists
- GPs/Addictions Doctors* working in the addiction service
- Pharmacists
- Counsellors
- Rehabilitation
- Residential
- Voluntary sector representatives not funded by the HSE
- Nurses
- Service Users
- General Assistants
- Education/Prevention
- Outreach Workers

In addition to the meetings with staff, a number of existing reviews of the service have informed this report and existing policy documents (covered in more detail in the relevant section), such as the interim drug strategy, have been used.

* Note that the Dublin North City and County Addiction Service uses the term GPs but this document refers to them as Addictions Doctors as this better captures their role and helps with distinction from services provided in primary care.

Service Configuration

The Dublin North City and County Addiction Service is primarily centred around 6 Drug Treatment Centre (DTCs). In addition to these 6 centres, there is also one mobile dispensing clinic and a further 14 satellite clinics which are primarily engaged in liaison, community and outreach work. The primary function of the DTCs is to assess opioid dependence and dispense methadone. As such, each clinic hosts a number of pharmacy professionals who are responsible for the dispensing of methadone but the DTCs are not formally managed. There are a number of additional psycho-social functions attached to a number of the DTCs.

The number of service users dispensed to in each DTC is shown below, (Table 2) and an additional 739 service users are dispensed to in the satellite clinics[†]. The current distribution of dispensing clinics is not integrated into an effective multi-disciplinary model of working and needs to be rationalised and re-structured so that they are reduced in number, integrated and coterminous with the locality based team model (see below).

Treatment Delivery

Table 2: Methadone Dispensing by DTC

DTC	Total Patients from Pharmacy Submission	Total Patients from GP Report from HSE
The Mews	146	144
Tolco	97	124
Wellmount	160	207
City Clinic	284	288
Domville House	242	248
Darndale	144	152
Mobile Clinic	63	58
Totals	1136	1221

The DTCs and satellite clinics are also staffed by a number of General Assistants (GAs) who perform a wide variety of roles including urine testing and portering.

Urine Analysis

A sub-group of all service users receiving methadone in DTCs are selected at random to provide a urine sample to test for methadone or illicit drugs; this being a reduction from the twice weekly urine samples taken during the methadone induction period (Downey, Flood, McGoldrick, Kumar., Martinez, & Zayed, 2012). This is in accordance with current HSE policy which should be aligned with emerging national policy on this subject. Farrell and Barry conducted a review of the Irish methadone treatment protocol in 2010 and

[†] Data collated from Submitted Comparative Study doc

made a number of recommendations around urine analysis, all of which are supported by this review. These include the following:

- Cessation of frequent, regular urine testing.
- Cessation of supervised urine testing except for where there is a legal requirement for supervision and that sample freshness requires verification.
- Consideration of saliva testing as an alternative.

Understanding Need

There is no mechanism currently in place nationwide to assess the need for drug and alcohol misuse services at a locality level. This makes it difficult for the Dublin North City and County Addiction Service to quantify need and respond accordingly.

The addictions service is currently well resourced and by way of illustration a comparison can be found in Appendix 5.

The HSE and the Dublin North City and County Addiction Service need to develop a comprehensive assessment of population need for substance misuse, this may well require liaison with other appropriate organisations. This will help inform both strategic and operational decision making, and assist with the matching of funding and service provision to population need.

In the UK, local authorities carry out Joint Strategic Needs Assessments (JSNAs), which look at local needs and inform strategies for addressing them. It is recognised that it will be difficult for the HSE and the Addiction Service to carry out assessments in this detail as much of the organisational framework and agreements are not yet in place in Ireland; it is however, suggested that this is a goal that the service should move towards.

Areas for Development

It is difficult to quantify levels of unmet need as there is only limited data available. The National Documentation Centre on Drug Use noted in 2007 that datasets in Ireland are insufficient to support effective modelling and needs assessment.

Notwithstanding the difficulties in the availability and collection of reliable data and information, some of evident priority needs have been identified and are set out below:

- Alcohol misuse (and comorbid opioid use) - There is virtually no formal service in the community available for those with alcohol problems, both as a primary presentation and as a comorbidity with opioid. It is recognised that many staff within the addiction service come in to contact with alcohol misusers on a regular basis and provide limited care within the resources they have, but this has not been formalised and there are few specific service(s) for the treatment of alcohol misuse. Given the extent of the problem in Ireland this is regrettable.
- Detoxification - Whilst there is some provision for detoxification, this is limited, particularly community based detoxification.
- Non-opiate drug misuse - The focus of the addiction service has not changed much in recent years and is almost solely focused on the treatment of opiate misuse, primarily through a supervised, methadone maintenance programme. This means that there are a range of substances, both illicit and prescribed, that are being misused but for which there is little available treatment. These include benzodiazepines, cocaine, cannabis and other emerging street or recreational drugs. Moreover, there is limited data on the scale of the different needs of the population which makes designing a service to treat their needs challenging. This suggests that a needs assessment of the nature and level of non-opiate drug misuse is required in Dublin North City and County .
- Comorbid mental health disorders - Comorbid mental health disorders are a significant problem and the availability of and access to treatment is limited and unclear at present.
- Physical Healthcare - Links with primary care and other physical healthcare services lack clarity and need to be addressed through stronger links with primary care and other providers of physical healthcare as the prevalence of significant physical health problems is high in drug and alcohol misusers.

Summary

Many elements of the addiction service in Dublin North City and County are working well and the appointment of an interim clinical lead and service manager are encouraging. Some teams have good morale but there is still considerable variability in the delivery of effective services and interventions for people with drug and alcohol misuse.

The review team considers that the current service configuration is sub-optimal meaning that it is not always possible for staff to deliver care in line with an evidence based tiered approach (as shown in Fig 1). The service currently consists of a number of professional/staff groups, some of whom appear to have limited formal interaction with one another, making the tasks of individual staff members and staff groups more difficult. There are also a number of ad-hoc arrangements in place, with staff providing good services but again these are often not properly integrated within the wider service system.

In line with international opinion, the principle of recovery should underpin all treatment from the point of first contact. It should again be emphasised that this review does not suggest that the treatment of opiate misuse with methadone should be time limited. Moreover, recovery should not be seen solely as stopping methadone; an individual may be considered to have recovered whilst still in receipt of methadone treatment through improvements in other social and health factors.

Services have typically evolved, often without an overall strategic direction, responding to specific issues or opportunities. These problems are firmly located at the service level and are best summarised in three key factors which are also recognised in national health, in particular, the Brennan report:

1. No clarity of purpose or strategic direction for the service resulting in treatment primarily geared towards methadone maintenance at the expense of other substances and alcohol.
2. A lack of clinical leadership and accountability in parallel with a lack of overall management responsibility and accountability - both of these issues are apparent throughout many levels of the service and make it difficult for the service to respond effectively to policy, population need and individual need.
3. A lack of clarity of funding sources, mechanisms and processes for service provision making it difficult to specify the nature of the service that should be provided, to monitor performance and to redesign the service effectively and to develop staff roles.

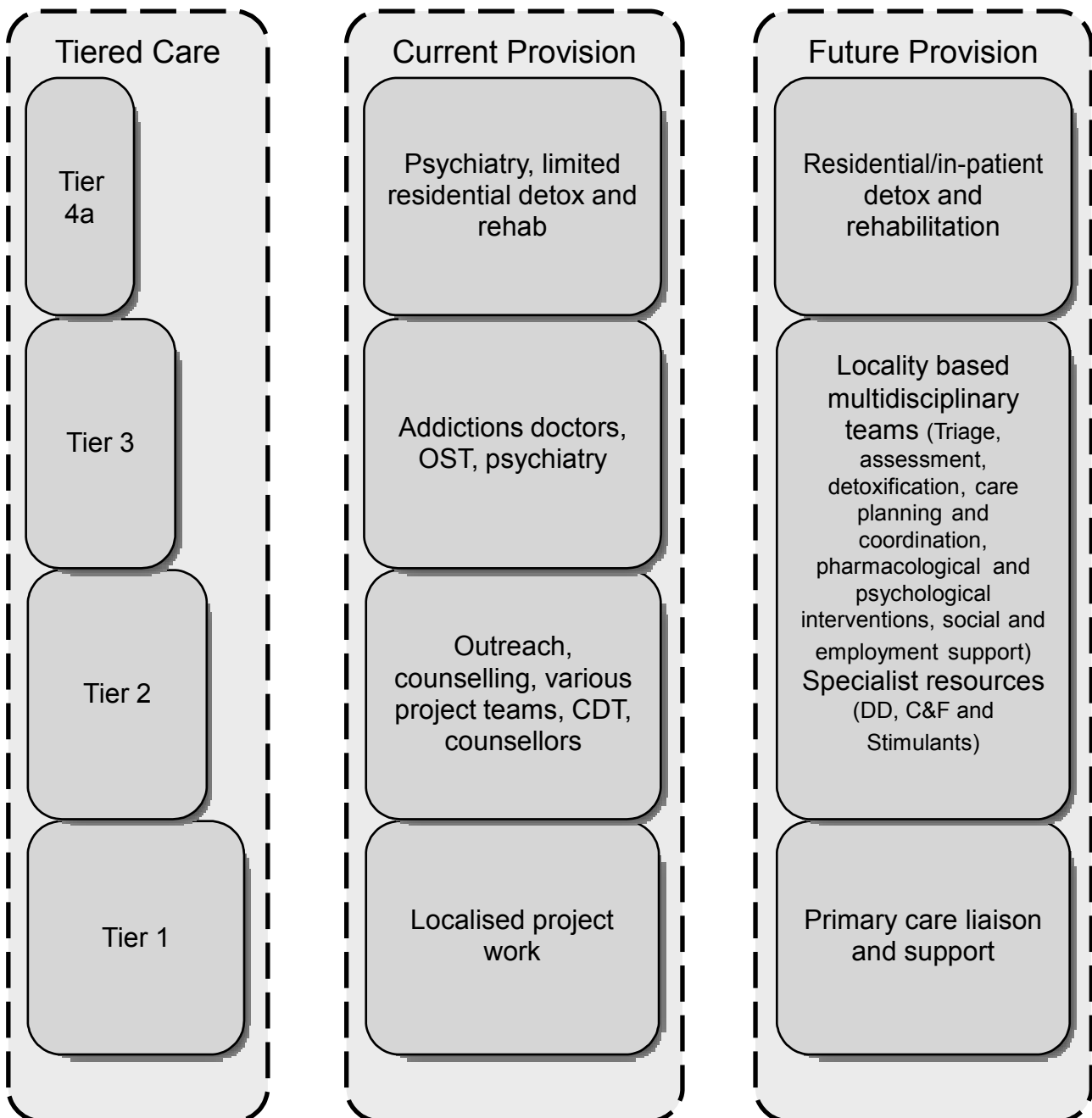
From discussions with the HSE, service staff and analysis of submitted documents it is clear that the issues highlighted above are acknowledged as significant problems in the Dublin North City and County Addiction Service.

Service Recommendations

This section outlines those recommendations relating primarily to service redesign. It is understood that it will take significant time and dedicated resources to implement all of the recommendations included here.

Figure 2 below shows the recommended tiered care pathway shown in Figure 1 and maps out current provision and where future provision might sit against the structure. The below should be seen as a way of conceptualising service structures as opposed to a model of care and each tier requires care pathways to ensure seamless movement through services for service users.

Figure 2 - Tiered Care Comparison



Recommendation 1:

Addiction Services should be delivered around clinical care pathways for drugs and alcohol with a focus on recovery, “an individual, person centred person centred journey, enabling people to gain a sense of control over their own problems, the services they receive, and their lives and providing opportunities to participate in wider society”. - Pathways should be developed as the common method of providing care in the addiction service. These should include separate and substantial pathways to address the major problems facing the service including opioids (and polydrug misuse), alcohol and stimulants as well as pathways for detoxification, children and young people and more limited pathways for complex needs such as patients with severe mental illness and drug/alcohol misuse (dual diagnosis) and residential rehabilitation.

Pathways be developed in the context of the four tiers above and where appropriate should encompass general care based in primary care settings through to specialist inpatient services. This principle applies to all drug and alcohol pathways. Furthermore care pathways should be highly integrated, drawing on multidisciplinary teams and external agencies requiring high levels of integration.

Service users and case managers should be able to draw on a variety of agencies, disciplines and approaches. For a service user on methadone maintenance this might include access to housing support, social care, psychological therapies and physical healthcare services in addition to receiving methadone.

The NTA have a number of example care pathways through substance misuse treatment services in the UK (DH, 2001) which are broadly applicable to the addiction service in Dublin North City and County. It is important to stress the interconnectivity of the different pathways and the importance of the care planning process for both service users and clinicians to successfully navigate their way in, through, and out of a care pathway.

Another key component of the successful implementation of care pathways is the use of evidence based interventions and this is covered in recommendation 9. An important element of delivering the most effective care is the ability of the Dublin North East addiction service to act as a unified, cohesive and integrated whole with strong clinical and managerial leadership (see recommendations 4 and 5). In addition to properly respond to population need, the service needs to build and maintain relationships with a large number of external organisations, with formal referral mechanisms between services.

This requires an extensive mapping exercise to be undertaken to enable the HSE to be aware of the range of organisations, services and projects that are operating across the area. This will also allow gaps in provision to be identified and addressed.

The ability of the addiction service to coordinate care with specialist mental health services is important. This review did not look at mental health service provision in detail as it is outside the scope of the project, however, there are important principles relating to mental health care that are worth highlighting.

This will need engagement and change from both addictions and mental health services and should be a 'two way street'.

As a starting principle, all service users receiving treatment for addictions should have access to mental health interventions as and when required. These may be provided by the addiction service, specialist mental health services or a combination of the two. This should be an important part of the care plan and where links are not yet developed between substance misuse and mental health services it will be for the clinical lead(s) to engage with mental health and build and maintain effective relationships.

Service specifications and agreed, formal referral systems are key elements of this recommendation and will help support implementation. This will require significant improvement in communications across the service and joint working with both primary care and mental health services to move this forward. This will help to ensure clarity over when it is appropriate to refer between substance misuse and mental health, and who is responsible for which element of care.

Recommendation 2:

Addiction services should be organised to treat all addictions (including alcohol and stimulants), around multi-disciplinary teams which are locality based. The precise boundaries of the teams should take into account and build on the locality based work done by the existing Drug Treatment Centres (DTCs) and the Drug Task Forces. - Each locality team should be made up of a number of appropriate disciplines be supported by clinical leadership, management and administration.

The work of the Drug Treatment Centres provides an opportunity to build local, multidisciplinary teams. These teams should provide case coordination and provide a range of interventions, and be able to access and refer on to a range of other services.

Each locality team should have a manager and a lead clinician, both of whom report to the Dublin North City and County Addiction Service senior management team. The lead clinician for each team could be a senior member of any discipline (e.g. nurse, addiction doctor, counsellor, and pharmacist). Figure 3 shows a suggested structure for locality teams and their place within the overall structure of the addiction service.

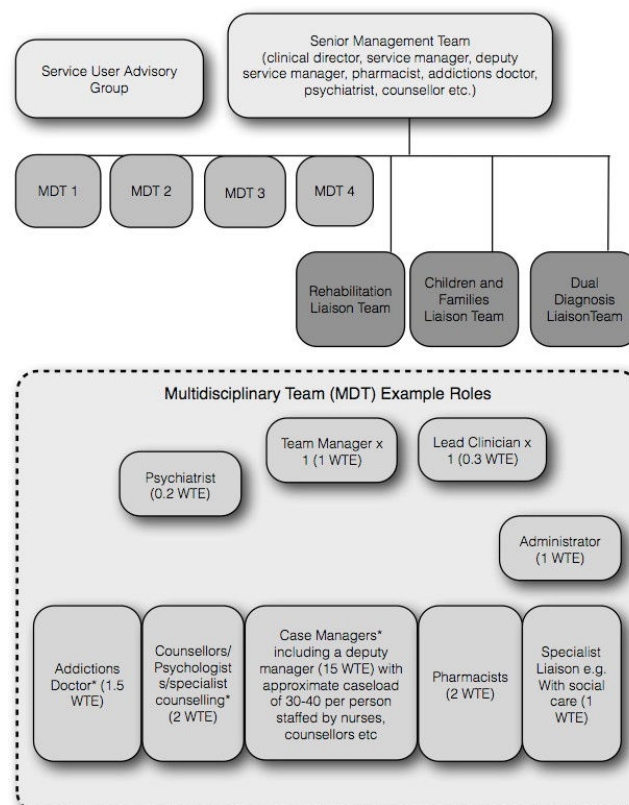
The majority of the team should take on a case management role (with case managers drawn from a range of professional backgrounds), each with their own case load and care coordination responsibilities. It is recommended that existing staff are identified and trained to become case managers as either as part of or for all of their duties. The Rehabilitation Integration Service (RIS) and others already provide elements of case management and this might help inform the wider roll out of the model.

In addition to case managers, the team should include designated positions of pharmacist(s), addictions doctor(s), counsellors/psychologist(s), and rehabilitation worker and have regular, designated sessions from a psychiatrist. Teams will need sufficient administrative support to operate effectively. Members of the team should also operate in specific liaison roles to ensure links with other teams within the addiction service and external agencies are maintained.

There are the three salient and parallel implications arising from the need to develop multidisciplinary locality teams; restructuring, redeployment and training.

- **Restructuring** - In parallel with redeployment and training, the service as a whole will require significant reorganisation. Whilst this could be considered to be very similar to redeployment it is in fact a distinct element as it refers primarily to the systems and process within which staff operate, as opposed to the re-designation of functions. This has a number of subsidiary implications, such as the reorganisation and redirection of funding away from methadone maintenance and in to alcohol and other drugs treatment, a shift in focus from the substance to the person, a focus on the delivery of treatment in the community in common with the general recommendations in this report, and structures that support multidisciplinary working as part of a care plan.
- **Redeployment** - The Dublin North City and County Addiction Service employs a large number of competent, professional staff. This review does not suggest that new staff are employed as part of reconfiguration. Instead, as suggested elsewhere in the report, existing staff need to be redeployed to provide a comprehensive substance misuse service. For example, a number of staff already operate as case managers so a number of staff groups should be redeployed to deliver treatment, either as part, or all of their role.
- **Training** - Staff who are to be redeployed, for example, to treat alcohol misuse, need to be trained to deliver effective, evidence based interventions (see recommendation 9). Staff will also need training to understand new assessments procedures, referral systems and outcome measures.

Figure 3 - Locality Team and Service Structure. Each team should have a clear links with primary care.



Recommendation 3:

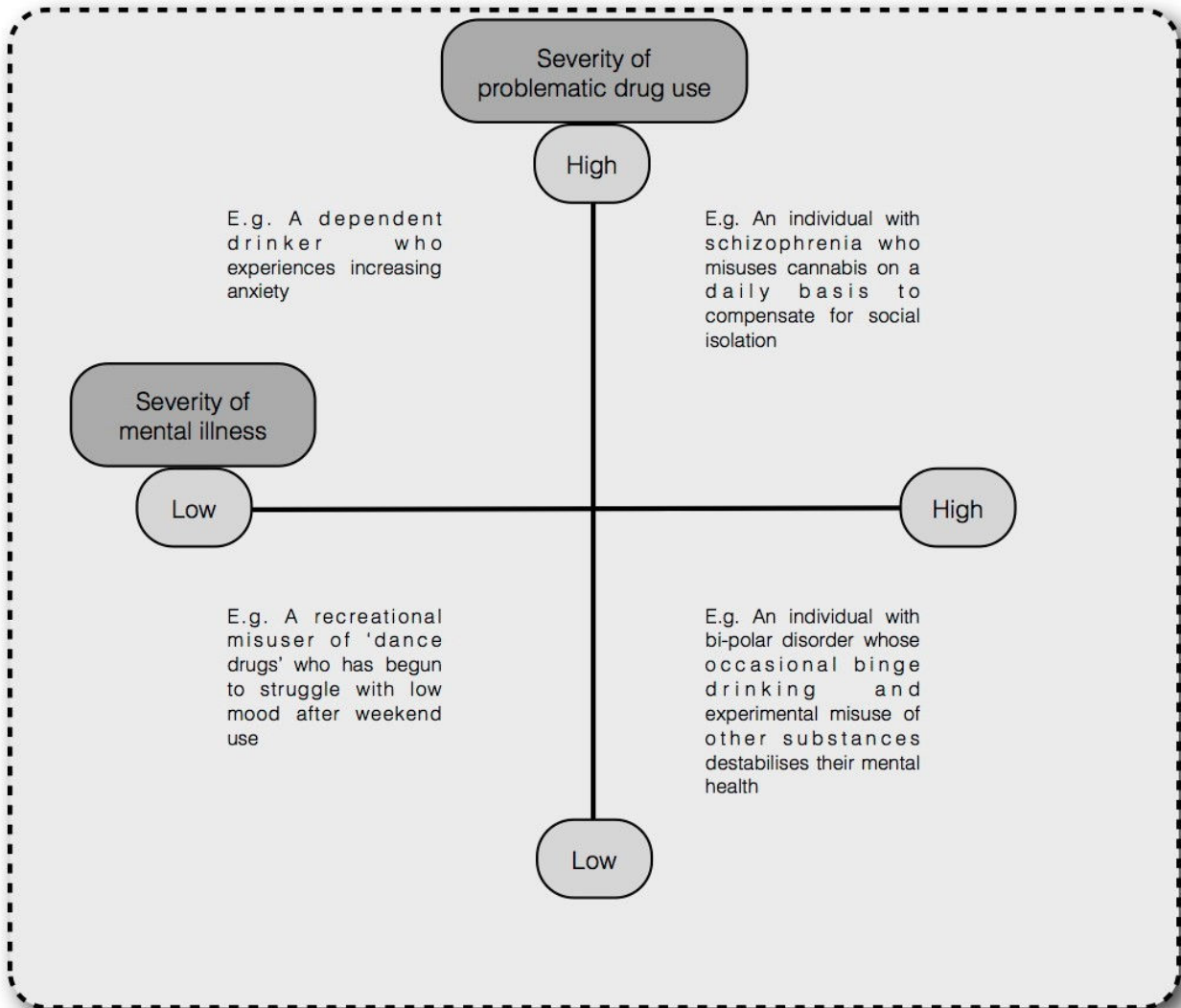
The addiction service should develop limited specialist resources which are capable of operating across the Dublin North City and County area. These should address dual diagnosis for mild to moderate mental illness, rehabilitation and detoxification and Children, Young People and Families. A primary function of the specialist resources should be to support local teams in delivering services whilst retaining a limited direct clinical role. – This will require local teams to develop expertise in managing dual diagnosis, detoxification and working with families and young people. It will require the development of discrete roles with the team and clear criteria when to refer on to specialist services.

In common with the locality teams, each team should have dedicated management, administration and a lead clinician. To some extent, psychiatry already operates a similar model as recommended here, with a lead child psychiatrist for example, but it is important to stress that these teams should be able to benefit from direct multidisciplinary support, such as psychology and outreach, and have access to wider support from the locality teams.

Close working with specialist mental health services is key to the effective delivery of all elements of the service but becomes particularly important for patients dual diagnosis (severe and complex mental disorder and substance misuse). This is emphasised in *A Vision for Change* (Expert Group on Mental Health Policy, 2006). Dual diagnosis is of course very common in this population group, with evidence suggesting that between 35% and 60% of people with a severe mental illness (SMI) also have a substance misuse problem (Hussein Rassool, 2006), the vast majority of whom are treated within secondary care mental health services. However, whatever its severity dual diagnosis is associated with poorer outcomes and may require treatment by parallel systems or there may be a role for advise and consultation from substance misuse services for some patients. A useful way to conceptualise the integration between mental health and substance misuse services is shown in Figure 4 (DH, 2002).

The work of the children, young people and families' team should build upon existing work underway in Dublin North City and County working with this client group. Clear and coherent pathways for children and families need to be developed and relevant services/ organisations (including educational provision and social care) identified that can link to both locality teams and specialist resources. It is important to emphasise the role of family liaison and carers organisations for this client group.

Figure 4: The Scope of Coexistent Psychiatric and Substance Misuse Disorders (Quadrant Minkoff Model)



Recommendation 4:

Effective clinical leadership is required for the whole service in the formal and permanent post of a clinical lead/director who should jointly chair the senior management team (SMT). Each locality team should also have an identified clinical lead. Clinical leadership and the role of clinical lead should be open to all professions. Effective clinical leadership is essential to the success of the Dublin North City and County Addiction Service. This should be a formal post with a job description. As a principle, this post should be open to all professions/professionals with the requisite skills, experience and qualifications. This will enable the development of an effective system of clinical governance. The post of clinical lead for the service should be aligned with other similar positions in Ireland which are generally carried out for a period of three years within acute settings.

The clinical lead will require a range of skills and experience to carry out this function effectively. This will include the following:

- Leadership and management experience.
- Understanding of healthcare provision and appreciation of the healthcare system in Ireland.
- Excellent clinical knowledge relating to substance misuse.
- Understanding of clinical governance
- Excellent clinical skills
- Experience of collaborative management at a senior level.

The above skills and experience should contribute to the following components of the role:

- Development and implementation of a clinical leadership strategy to ensure that the Dublin North City and County Addiction Service operates in line with national policy and best practice guidance.
- Clear strategic clinical direction and effective advice to the management team to support an effective, user focussed addiction service with a high standard of clinical care and the best possible use of resources.
- Leadership in the development, review and evaluation of clinical care pathways, to promote clinical effectiveness and innovation and to eliminate waste.
- Quality in clinical care delivery, ensuring that regulatory and statutory standards are achieved.
- Visible clinical leadership to staff, ensuring that there are appropriate structures in place to address professional and developmental needs with an appropriate emphasis on the development and implementation of a training and education strategy.
- Development of clinical governance structures, roles and responsibilities based on a multi-disciplinary approach which emphasises collaborative team working.
- Ensuring effective relationships with external stakeholders with a particular focus on clinical perspectives, quality and service user experience.

- A role in service management alongside the addiction service manager including jointly chairing the senior management team.

Recommendation 5:

Effective management and strategic leadership is required and is fundamental to the delivery of effective care. All staff working within the service should have clear lines of accountability. Effective management at strategic levels and the operational level is required to deliver a competent and fit for purpose service to individuals. This is fundamental to the delivery of effective care. All staff working within the service should have clear lines of accountability.

The manager of the Dublin North City and County Addiction Service should have responsibility, alongside the clinical lead for the performance, development and strategic direction of the service as a whole.

An important part of this will be the development of local teams, each with an appointed manager. These managers will in turn be accountable to senior management. Figure 3 above provides an overview of this model.

Recommendation 6:

The addiction service should be outcomes focussed with agreed outcome monitoring and performance management processes in place. The service needs to be clear about what outcomes it aims to achieve and develop the tools and processes (for all drug and alcohol problems), including an electronic data system to ensure service wide implementation.

The addiction service currently has no system for routine outcome monitoring thereby making it impossible to assess the efficacy and performance of the service as a whole as well as that of individual practitioners.

A key element of implementing this recommendation is the procurement and use of an electronic data collection system to be used across all elements of the Dublin North City and County Addiction Service.

Developing robust outcomes measures and a performance management framework should be a key part of the redesign of the service.

There are a number of different systems available for measuring outcomes in substance misuse treatment. The Treatment Outcomes Profile (TOP) was developed by the NTA and provides a useful framework for developing outcomes in Dublin North City and County . It is recognised that there is no equivalent of the National Drug Treatment Monitoring System (NDTMS) in Ireland, limiting direct transferability but many of the measures used in TOPs remain applicable to the Dublin North City and County setting. There are of course a number of useful proxy measures which can help with understanding the performance of a service, including waiting times and retention in treatment. It is recommended that these are used

in conjunction with a formal outcome measure which has been developed specifically for substance misuse.

Routine monitoring outcomes and performance represents a significant culture shift for many practitioners and it is necessary to recognise and address this. It may be helpful when thinking through implementing outcomes monitoring to consider the overall purpose of the service and develop further understanding of how staff view their own role, the roles of colleagues and their place within the service. There are already some good examples of outcome monitoring in the service, particularly in those organisations providing rehabilitation. These are examples that can be built upon and developed.

Recommendation 7:

A clinical governance structure should be developed for all clinicians working in the addiction service. Each profession working in the service should have clear lines of clinical accountability, clear understanding of acceptable practice and a clear understanding of the consequences of acting outside of this.

Good clinical governance is the responsibility of all working in the addiction service. It is recognised that establishing effective clinical governance is a complex process. The NTA have produced a detailed but accessible guide to developing good clinical governance in substance misuse services (NTA, 2009). Whilst the document was developed for services operating in the United Kingdom, the principles, processes and structures remain relevant in Ireland.

An effective clinical governance structure will support:

- The establishment of lines of responsibility and accountability, A programme of quality improvement, including clinical audit.
- Procedures for managing risk and incident reporting.
- Procedures for identifying and addressing poor performance.

Recommendation 8:

Comprehensive assessment of need and regular reviews of the assessment should be central to the delivery of addiction services in the Dublin North City and County area both to inform service structure and evaluate the delivery of treatment.

The Dublin North City and County Addiction Service should develop methods of assessing, evaluating and the response(s) to need in the area.

This should inform estimates of the likely numbers of people requiring treatment (including those with alcohol related problems), and the required level of interventions to meet those needs.

This information should be reviewed and updated regularly to inform the direction of the addiction service and the structure and content of care pathways and the methods of treatment delivery should be designed in response to needs assessment.

Operational Recommendations

This section outlines those recommendations relating specifically to implementation and more operational elements such as interventions.

Recommendation 9:

All individuals receiving treatment and support from the addiction service should have agreed care plans - Care plans should be reviewed and updated regularly, involve multidisciplinary teams and should react to the needs of the service user to enable them to move towards recovery when they are ready and able. Service users should have a named person (case manager/key worker) who will explain and agree individual care plans and maintain contact with the service user through their care pathway.

Care plans should demonstrate how an individual navigates the care pathway, which in turn should encompass care based in primary care settings through to specialist inpatient services. This principle applies to all drug and alcohol pathways. A care plan should include the following:

- The systematic assessment of an individual's needs including individual treatment goals.
- The development of the plan in consultation with service user
- The designation of a case manager (key worker) to coordinate, monitor and review care in discussion with the service user (see recommendation 2).
- Facilitation of access to the full range of appropriate interventions.
- Regular multi-disciplinary evaluation, monitoring and review of care to ensure the individual as access to the right support.
- Service user focused outcome monitoring (see recommendation 6).

The above, or variations on the above, should be agreed with all individuals in receipt of services. Two helpful documents developed by the NTA around care planning are Routes to Recovery (NTA, 2010) and Undertaking Needs Assessment (NTA, 2009).

Recommendation 10:

In addition to individual care plans locality teams should provide a consultation and support service to care providers and those individuals with drug and alcohol problems who are treated by primary care services. This can take the form of advice, consultation and training and development. This recognises the considerable role primary care services have in (a) providing significant interventions, for example screening and brief advice for alcohol problems, (b) identifying and referring those with significant drug and alcohol problems and (c) providing care, including physical health care, to all problem drug users. It is therefore essential that staff from primary care are involved in the

development of the care pathways and in particular the referral criteria for the various clinical care pathways.

Recommendation 11:

All interventions, treatment and support offered to individuals should be evidence based and those providing treatment should have appropriate training and supervision to deliver them - The National Institute for Clinical Excellence (NICE) provides recommendations, based on comprehensive reviews of the best available evidence, for treatments and interventions for this client group.

A number of the salient treatments have been outlined in a previous section and below are listed relevant NICE guidelines and others from which the recommendations were drawn:

- Drug misuse: opioid detoxification, (NICE 2007)
- Drug misuse: psychosocial interventions, NICE 2007
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE 2011)
- Alcohol-use disorders: preventing the development of hazardous and harmful drinking (NICE 2010)
- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications (NICE 2010)
- Medications in Recovery, John Strang (NTA 2012)
- Drug misuse and dependence, UK guidelines on clinical management, (NTA 2007)

In addition to the drug and alcohol specific interventions, treatments offered as part of the care pathway, for example for depression, should similarly be evidence based (NICE, 2009, 2011).

Recommendation 12:

There should be integrated detoxification and rehabilitation services developed as part of the care pathway. Most detoxification should be community based and managed by locality teams and where appropriate in primary care. For some, with complex mental health problems and significant physical health problems and other groups with specialist needs, specialist residential or inpatient detoxification treatment will be required.

Following a successful detoxification some individuals may require a period of residential rehabilitation, where possible with integrated detoxification and rehabilitation services and based on agreed evidence based entry (and discharge) criteria (see the relevant NICE guidelines 2009, 2011) for details of such criteria).

Recommendation 13:

Service users should be central to the design and delivery of care and they should have a formalised role in provision - Formal structures should be in place to enable service users to influence the design and evaluation of care. This is a thread that should run through all

aspects of the addiction service.

The establishment of formal structures for enabling service users to have funded positions in decision making fora is critical to the success of the Dublin North East addiction service. Care should be taken to avoid tokenism.

Service users should be empowered to be able to have meaningful impact at all levels of the service. This includes positions on key groups and the establishment of a service user advisory group, but will also require support for service users to be in place to ensure that input is meaningful. This can range from the payment of expenses to providing training and support about systems and processes.

Consideration should be given to involving service users in the appointment of all senior staff. They will require appropriate briefing and training prior to being able undertake this function

Recommendation 14:

An implementation manager should be appointed and a steering group with decision making authority should be established to implement the recommendations in this report - This group should include senior HSE management, service users, professionals and voluntary sector representatives. Subsidiary working groups and committees should report in to this group to aid implementation.

A detailed implementation plan with dedicated resources is required as a first step. This should be broken down in to manageable tasks and actions with clear responsibilities for delivery driven by senior level but also by those staff 'on the ground'. All groups noted in Table 7 below should include service user representation wherever possible.

In addition a clear communications strategy is required for the successful implementation of this review. This needs to include plans to ensure that all staff are clear about what implementation means, the encouragement of 'champions' to drive change at a team level and the importance of clinical and management leadership. Staff need to be signed up to an overall vision for the service and this can be achieved through consultation, engagement and clarity to reach consensus.

An outline implementation plan should include some of the following (note a number of these actions/tasks run in parallel):

Example implementation plan

Action/Task	Lead Person(s)
Establishment of senior steering group with terms of reference, including representation from multiple disciplines and service users.	Addiction service manager
Appointment of clinical lead via a formal recruitment process.	SMT

Action/Task	Lead Person(s)
Appointment/designation of named persons and working groups who report to the steering group, with responsibility for specific elements of implementation including: <ul style="list-style-type: none"> • Implementation manager • Performance lead (and performance working group) • Training lead (and training working group) • Liaison lead (taken from treatment team) • Staff engagement lead (and staff engagement working group) • Care pathway design expert (and care pathway working group) • External relations/communications lead (and working group) • Needs assessment working group 	Clinical lead and addiction service manager
Identification of training needs and appropriate training sourced and developed.	Training lead and clinical lead
Care planning processes, tools and staff agreed.	Care pathway design expert, implementation manager, clinical lead and staff engagement manager.
Redeployment and training of staff to deliver care plans.	Clinical lead, staff engagement manager and training manager.
Needs Assessment	Needs Assessment Working Group
Service mapping and engagement, for example with social care and primary care.	Liaison lead and engagement lead
Development of referral protocols and service specifications.	Clinical lead
Development, redeployment and restructure of service to meet need, including alcohol for example, based on referral protocols and service specifications developed above.	Addiction Service manager and clinical lead.
Appointment of management and establishment of management accountability at all levels of the service, likely to be based on locality.	SMT
Development and application of outcomes monitoring and performance management.	Addiction Service manager, performance manager and clinical lead.
Procurement of electronic data system	Performance lead and addiction service manager

Conclusion

The recommendations contained in this report are wide ranging and will be challenging to implement. This report does not specify timelines for implementation but it should be recognised that a significant period of time will be required to reconfigure the Dublin North City and County Addiction Service. There are issues that are outside of the scope of this report, such as contractual obligations, union agreements and the wider context of the healthcare system in Ireland - an example of this being handwriting exemptions consuming a considerable amount of clinical time. Addressing these issues requires substantial consultation, the development of good will and consensus. The implementation of these recommendations should therefore be wide ranging, engaging and collaborative.

Building on some of the existing work that is already underway, both in the HSE and in wider health policy initiatives in Ireland, this report highlights some of the challenges that are faced in implementation and some of the structures and processes that will be helpful in overcoming them. A detailed implementation plan will need to be developed in Dublin North City and County including key actions and timescales. This plan should be owned by the service as a whole but equally requires dedicated management and leadership to reach a successful conclusion.

It is clear that there is substantial work to be done to enhance, develop and reconfigure the Dublin North City and County service but doing so will enable the service to proactively respond to policy developments and population need against a challenging financial background. The service already has many of the elements contained in this review, albeit often isolated and not always properly coordinated, but this gives a sound basis upon which the service can move towards delivering high quality interventions. Implementing the recommendations in this report will not only bring the service in line with national policy expectations but will place it in a strong position to become the leader in addictions treatment in Ireland.

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Appendix 1: The Review Team

Professor Stephen Pilling:

Professor Pilling is Professor of Clinical Psychology and Clinical Effectiveness at University College London (UCL). He is the director for the Centre for Outcomes Research and Effectiveness (CORE), the National Collaborating Centre for Mental Health (NCCMH) and of the Psychological Interventions Research Centre (PIRC). He is also an honorary consultant clinical psychologist with Camden and Islington NHS Foundation Trust.

As part of Professor Pilling's role with the NCCMH he has produced clinical guidelines for the National Institute of Clinical Excellence (NICE) including guidelines on drug and alcohol misuse. Professor Pilling has a particular interest in the treatment of depression and the development and implementation of clinical guidelines.

Professor Pilling is heavily involved in the Improving Access to Psychological Therapies (IAPT) programme in England and is an expert on low intensity interventions, being the course director for the low intensity Psychological Wellbeing Practitioner (PWP) course at UCL.

Rob Hardy:

Rob is the project manager for the Psychological Interventions Research Centre (PIRC) based at UCL as part of UCL Partners (UCLP), one of the accredited academic health science networks in the UK. PIRC is primarily concerned with implementation of the latest research in mental health and psychological therapies specifically.

Rob is heavily involved in the Improving Access to Psychological Therapies (IAPT) programme in London having worked on the London IAPT implementation team for a number of years, leading on workforce and training, performance, recruitment and clinical assurance. Much of this work has now been incorporated in to his role with PIRC.

Dr Luke Mitcheson:

Dr Luke Mitcheson has worked in mental health and drug and alcohol treatment services since 1993 and SLAM since 1998. He is a Chartered Clinical Psychologist and Accredited Therapist with the British Association of Behavioural and Cognitive Psychotherapists. He has been involved in service initiatives for substance misusing populations, research focused on developing psychological treatment approaches and work with staff groups to deliver these interventions.

He currently works at Lorraine Hewitt House, which is the South London and Maudsley NHS Foundation Trust Drug and Alcohol Treatment Service in the London Borough of Lambeth. Since November 2008 he has been seconded one day a week to the National Treatment Agency where he works as part of the Skills and Practice Development Team. The National Treatment Agency is a National Health Service special Health authority established to improve the availability, capacity and effectiveness of drug treatment in England.

Dr Michael Kelleher:

Dr Michael Kelleher is a consultant psychiatrist and the clinical lead for the Lambeth addiction service in London at SLAM. He has held this post for the past ten years. He is currently clinical leads of the skills team at the NTA.

Dr Chris Ford:

Dr Chris Ford recently retired from General Practice in North West London, where she had been a partner for over 27 years. She developed special interests in working with people who use drug and/or alcohol, HIV and hepatitis and sexual health. She really enjoyed this work and learnt all of what she knows from the people she looks after and sees this as a privilege.

She was the founder of Substance Misuse Management in General Practice (SMMGP) and retired as its Clinical Director in 2011 and has published and presented widely about the care of people who use drugs in general practice. She is a board member of Release and a founder member of the UK Harm Reduction Alliance (UKHRA).

In 2009 she set up International Doctors for Healthy Drug Policies (IDHDP) to increase the participation of medical doctors in drug policy. From an early stage it was easy to see the links between policy, harm reduction and good drug treatment systems and IDHDP of which Dr Ford is the Clinical Director, is the doctors' voice in drug policy.

Katie Greenfield:

Katie Greenfield is the research assistant at PIRC and is responsible for collating information and carrying out research for PIRC projects. She previously worked within welfare-to-work as an employment advisor and has a BSc in Psychology and an MSc in Health Psychology.

Appendix 2: Terms of Reference

Objective

This document sets out the Terms of Reference for the Dublin Addiction Service Review which is being undertaken by the Psychological Interventions Research Centre (PIRC) at the request of the Addiction Service Review Committee Dublin North.

Background and Context

Drug and alcohol misuse services in Dublin North City and County are configured to treat and manage heroin use and as such primarily operate a methadone based treatment model. However, this treatment model is no longer in line with national policy and local trends following an interim substance misuse strategy which notes that the heroin problem in Dublin has reduced. The strategy brings new focus on alcohol misuse and notes the increasing prevalence of cocaine use. North Dublin HSE is keen to evaluate the efficacy of current service provision with a view to improving efficiency and reconfiguring the service to align with national policy and local need.

Review Objectives and Considerations

The review will seek to make a number of recommendations, primarily based around NICE guidance, and other evidence based approaches, and implementation expertise in this area. The review will consider current provision, staffing structures, pathways and interventions and make specific recommendations on how the Dublin North City and County Addiction Service can bring provision in line with current best practice and evidence.

The review will consider the following:

- Recommendations on refocusing provision from a substance misuse, methadone maintenance service to a substance misuse and alcohol focused service.
- Recommendations of efficient approaches
- Promotion of evidence based practice
- Improvements in service structure design and service delivery to improve outcomes

The review will specifically look at the following operational considerations:

- Skills and knowledge of primary care clinicians to deal with substance misuse and any training implications
- Treatment protocols to support a move towards recovery
- Improving access to primary care for drug and alcohol users
- The implementation of NICE guidelines and other evidence based approaches
- A needs based distribution of care across practices

The review team will undertake the following:

- Review data from relevant stakeholders in order to evaluate current service provision, especially with regard to urine analysis, overtime, client / staff ratio and prescribing
- To make recommendations with regard to best practice in relation to patient care and quality of services.
- To ensure that recommendations are realistically implementable in light of current funding restrictions and staff resources.
- To inform the review committee of preliminary results with a view to having the final report ready for October 2012.
- To present findings in a structured format that will be understood by both service users and providers.
- To involve service users in the review process.
- Identify how best practice (national and international) may improve/be integrated with addiction service delivery in Dublin North.
- Providing evidence-based recommendations to close gaps and minimise duplications in service.

Reporting

The review group will report to the review committee of the HSE Addiction Services. The review group will work closely with the addiction service manager in reviewing relevant data and supporting the team with information pertaining to the research project. Any changes to the priorities or any difficulties arising which may delay or interfere with research progression will be brought to the review committee.

Suggested Timeline

The review is to be completed by October 2012 with a draft for comment for September 2012. Implementation is expected to take place throughout 2013 following a consultation process. Below is a broad suggested timeline, note some details may change due to diary commitments.

- Terms of Reference and Review Team CVs to be collated and sent to Review Committee - end of June
- Initial data requests to be considered and requested- mid July
- Outline proposal to be completed and submitted to Review Committee - mid July
- First of suggested three visits to Dublin by UK team to be organised for late July Second visit to be arranged for early September and final visit to be arranged late September/ early October
- Draft report submitted - September (All)
- Final report submitted - October (All)

Appendix 3: Meetings Held

Below is a list of meetings held between the review group and various members of the Dublin North City and County Addiction Service.

24th July 2012, Ballymun, Dublin

Steve Pilling, Rob Hardy, Mike Kelleher and Luke Mitcheson met with senior HSE management to scope out the report and plan next steps.

The team then met with a number of staff representatives from both the statutory and voluntary sector to introduce the review and obtain contextual information.

27th and 28th September 2012, Ballymun, Dublin

Rob Hardy, Mike Kelleher, Luke Mitcheson and Chris Ford met with staff groups individually (as noted in the body of the report) as part of the consultation over a two day period.

27th November 2012, Ballymun, Dublin

Steve Pilling, Rob Hardy and Mike Kelleher met with HSE management to discuss the first draft of the review. The team then met with voluntary sector representatives to complete the consultation process.

Appendix 4: The Addiction Service

A number of organisations, statutory and voluntary sector, provide services for drug misuse in Dublin North City and County at present. This section gives a brief overview of provision in Dublin North City and County including staffing (where available), configuration and a description of each of the discipline's current role and activity.

This section is illustrative and is not intended as a comprehensive description of how the service operates nor detail all of the functions the various staff groups perform. There are limits to providing a comprehensive description of such a large and complex service and there is a significant amount of activity undertaken by disciplines within the staff group that is not covered here. The large number of organisations and disciplines that constitute the addictions service in Dublin North City and County which makes an exhaustive description of each of these difficult to achieve, moreover, such a review is unnecessary for the purposes of this report. Broad functions and professional groups are included here and the specific organisations highlighted are primarily for illustrative purposes only. This section is intended to provide the context for the recommendations contained in the report to be understood.

Service Staffing

According to the North Dublin HSE, Dublin North City and County Addiction Service has 1854 patients in treatment and provides support to a further 1009 in primary care[‡], there are 145.46 WTE addictions staff funded by the HSE distributed across a variety of professions. The vast majority are clinical staff with 14 staff (12.9 WTE) in administrative roles. In addition, there are a number of voluntary sector organisations funded from other sources providing addiction services in Dublin North City and County . Table 1 (based on data taken from the October census provided by the HSE) shows the numbers of HSE funded staff working in Dublin North City and County broken down by relevant profession/function.

Table 1: Staff Composition of Dublin North City and County Addiction Service

Staff Group	Staff Numbers	Staff Numbers (WTE)
Addictions Doctors	13	8.1
Administration	14	12.29
Community Welfare	1	1
Counsellors	24	21.42
Education	2	0.48
General Assistants	31	30.11
Local Drugs Task Force (LDTF) Coordinators	5	5
Miscellaneous*****	6	3.62
Nurses*+ Agency Nurses 4.5 WTE	7	6.61

‡ Report provided by North Dublin HSE

Staff Group	Staff Numbers	Staff Numbers (WTE)
Outreach	10	9.5
Pharmacists	22	20.3
Project Workers****	7	6.2
Psychiatrists	4	4
Rehabilitation	8	7.35
Rehabilitation Education	3	3
Residential***	7	6.48
Totals	164	145.46

*Clinical nurses with an additional 3 specialist nurses

**There are an additional 66 GPs working across primary care, those counted here work in the Addiction Service directly.

*** Keltoi staff

**** SOILSE and Talbot Centre staff

***** Social workers, project leader, teacher and chef

The next section draws together various sources of information, including face to face meetings, written reports and online submissions from staff, to briefly describe some of the salient issues relevant to the review of the Dublin North City and County Addiction Services[§].

Clinical Leadership

The service has an interim clinical director who is a consultant psychiatrist. The clinical director jointly reports with the addiction services manager to the operations manager for Primary and Community Care. These two posts also jointly chair the Management Team.

The issue of clinical leadership has been contentious in the addiction service, largely as a result of lack of clarity and direction over the qualifications, experience and importantly, the profession(s) eligible to carry out the role. In addition, there is lack of clarity around the role and function of the clinical lead but it is clear that the clinical director should have responsibility for clinical governance, overall clinical direction and the clinical performance of the service.

Management

As noted above, the addiction service manager jointly chairs the Management Group with the clinical director and both report to the Primary and Community Care operations manager. Limited overall direction as a result of lack of clarity and authority in leadership for the service has made it challenging to implement change. This also makes it difficult to hold staff to account for performance, ensure integration and provide operational and strategic direction for the service. As with clinical leadership, management structures for the component teams of the services are unclear and lack consistency.

§ A significant proportion of the information shown here has been distilled from meetings with individual staff groups and online submissions. References are given where applicable.

Addictions Doctors/GPs

There are 13 Addiction Specialist GPs in the service with a WTE equivalent of 8.1. These doctors are often the primary point of contact for service users but are not always linked effectively into multidisciplinary or primary care teams. This lack of a multi-disciplinary approach reduces the impact that the addiction doctors could have on service user outcomes.

There is currently no formal distinction in title between GPs working in primary care and those working as addiction specialists, despite the very different roles the two groups generally have. As noted above, this review uses the term addictions doctors to refer to GPs working in the addiction service in contrast to their colleagues in primary care.

Psychiatry

There are four Consultant Psychiatrists (4.0 WTE) working in the Dublin North City and County Addiction Service. There is a consultant psychiatrist located in each of three geographical areas: Dublin North City and County ; Dublin North Central; and Dublin North West. In addition there is a Consultant Child and Adolescent Psychiatrist in Addictions who works across these localities.

All consultant psychiatrists provide clinical sessions for the tertiary drug treatment service, the Drug Treatment Centre Board (DTCB), that manages service users who are often the most challenging and complex. The criteria however, for who are seen and treated by the psychiatrists, as opposed to the addiction doctors, are not well operationalised and can lead to poor use of specialist resources.

Pharmacy

There are 22 pharmacists (20.3 WTE) working in the Dublin North City and County Addiction Service whose primary role is to dispense methadone to service users. This is done via the Drug Treatment Centres (DTCs). It has been suggested by staff that around 50% of service users are on supervised daily doses. Dispensing is undertaken by two pharmacists at any given time and the DTCs are often open seven days a week. This high use of specialist pharmacists in part reflects the limited dispensing of methadone by community pharmacists as compared say to the UK. Consideration needs to be given to an expanded role for pharmacists beyond dispensing and to a rationalisation of the time spent on dispensing.

Nurses

There are 7 (6.61 WTE) nurses working in the Dublin North City and County Addiction Service 3 WTE are clinical nurse specialists in the areas of pregnancy, hepatitis C and the drug courts. In addition to this there are 4.5 long term agency nurses. (as shown in Table 1). Nurses are clinicians who provide a wide range of duties within the service. They have significant experience in managing referrals, collaborative practice and case management. The Nurses role has evolved over the last ten years, responding to the specific needs of the drug using cohort within the service including initial assessments, physical healthcare and wound management whilst also performing a variety of referral and liaison roles. Nurses provide some limited case management functions.

As with pharmacy, consideration to expand the role for nurses should be considered to include nurse prescribing, nurse led clinics and home visits.

The Drug Liaison Midwife integrates the maternity and addiction services and provides education and support to women who use drugs or who are drug dependent during pregnancy.

The Hepatitis C Liaison Nurse Specialist (HCLNS) is a resource to both clinicians and clients across the Addiction Service of Dublin North in the management of Hepatitis C.

The Drug Treatment Court (DTC) Liaison Nurse works as an addiction nurse specialist within the multi-disciplinary DTC team, acting as a source of expertise to the team and Judge regarding all aspects of treatment.

Counselling

There are 24 (21.42 WTE) counsellors working across the Dublin North City and County Addiction Service, each with caseloads of approximately 30-40 clients. The counselling service provide formal interventions such as cognitive behavioural therapy (CBT) for relapse prevention which the service has been trained in. Counsellors often have to operate proactively to generate referrals as there are no formal referral pathways or structures for this. This can mean that counsellors seek out patients for counselling as opposed to receiving formal referrals as part of a care pathway. Mandated counselling is a formal part of the treatment induction process but there is no evidence for the efficacy of this model and it is likely that this may disincentive some individuals from treatment. The purpose of mandated counselling should be reviewed and integrated into the role of the case manager. Consideration should also be given to a role for counsellors as case managers and their training in the full range of evidence based psychological interventions for drug and alcohol misuse.

Residential Rehabilitation Services

There are limited drug rehabilitation services in the Dublin North City and County Addiction Service but Keltoi and SOILSE are good examples of the resource that does exist. Both services are increasingly using a recovery model of treatment and are looking at ways of formally addressing substances outside of Opioids. However, this is a limited resource, for example Keltoi is able to utilise only 8 of 20 beds, and in the main, service users can only access residential rehabilitation once they are drug free, with patients generally having come from detoxification clinics. Consideration should be given to developing the role of these services in providing detoxification services for those who are unable to safely undergo a community assisted withdrawal. Criteria for entry to the services need to be made more explicit as do the objectives for admission to such units and the nature and content of the interventions they provide.

Rehabilitation Integration Services

There are 7 (WTE 6.35) Rehabilitation Integration Staff working across the Dublin North City and County Addiction Service. The RIS is the Addiction Service's case management and care planning service. It works with the service user to develop an individual long-term care

plan specific to their identified needs; supports them to identify and achieve their goals; and provides a continuum of care working in a collaborative way with other disciplines & agencies to develop and sustain progression. The RIS also meets with new entrants to treatment as part of their assessment/ induction so that they are made aware of the rehabilitation process and a brief needs analysis and preliminary care plan are developed. Additionally, the RIS is a core element of the assessment and support of service users accessing and completing residential detoxification and rehabilitation, with RIS officers also providing a residential liaison role in Cuan Dara and Keltoi. The RIS offer support to graduates of the Drugs Court. This way of working reflects the core principles of care planning, key working, case management and interagency collaboration which are promoted by the National Rehabilitation Framework (NRF).

General Assistants

There are 31 (30.1 WTE) general assistants (GAs) who perform a variety of roles within the clinic from portering through to the supervision of urine collection. The skills, knowledge and interests of the GAs also vary considerably. Given the view of the review group and previous reports that the level of urinalysis is too high, consideration should be given to the redeployment and training of GAs, with more experienced GAs being considered for training in case management roles.

Outreach

There are 10 (9.5 WTE) outreach workers in the Dublin North City and County Addiction Service. Outreach workers often hold an informal 'caseload' of patients who are not in formal treatment but do not carry a formal service caseload. Outreach workers work on the street to engage with potential patients and/or those at risk. In addition, they manage seven needle exchanges across the area. Outreach workers have variable levels of contact with other parts of the system and there are limited formal structures for their inclusion as part of a wider system.

The Talbot Centre

The Talbot Centre (established in 1983) is committed to developing supportive relationships with children, young people and their families whose lives have been affected by drug and/or alcohol use in the North Inner City.

The focus of work is on three levels:

1. *Prevention Work with children and young people at risk.*
2. *Working with young people using drugs and their families.*
3. *Educational Work / Community Interaction.*

The Talbot Centre's ethos is to work in a qualitative way with children and young people at risk. This involves working systemically to include families, schools, community etc.

Education

It is important to recognise the essential role of Education / Prevention programmes within the Dublin North City & County Addiction Service. The Education Team was established to provide training and support on addiction issues to both HSE staff and community and voluntary sector groups. The team assisted with the development of drug policies and devised addiction specific modules for university accredited addiction certificate and diploma courses. Staff numbers have been diluted and have not been replaced due to HSE recruitment pause. While there are some of the voluntary groups tasked with Dublin North East Addiction Service Review

provision of education / prevention initiatives there is still a requirement for cohesion between HSE and the voluntary sector to work on the education strand of the National Drug Strategy.

Additional Service Elements

There are a range of additional services who provide assessment, advocacy and case management functions. There are also many functions provided by voluntary sector organisations. The voluntary sector work in addictions is funded via a variety of sources, with some being funded directly by the HSE. However, many are funded via Drug Task Forces, which themselves receive direct funding from the Government. This means that they sit outside of the HSE funded addiction service that this review is primarily concerned but it should be recognised that this is an important and large resource, with strong community links, which the HSE services need to strengthen, that often compliments and augments the work of the HSE funded services.

The range of these services does complicate any rationalisation of addiction service provision as a whole in Dublin North City and County but whilst funding for these groups may change, for example being brought under the HSE umbrella, they represent a basis upon which to build community focused treatment services. The strong links with the community that these services have, coupled with the strong experience of some of them in case management, could assist in the overall reconfiguration of the service if they operate as part of a wider system of care in partnership with the HSE funded service elements.

- Drug Task Forces - Drug Task Forces were established to coordinate the overall development of community and voluntary drug services in local areas. They generally oversee networks and projects and are tasked with linking various service elements together. There are five local drug task forces in Dublin North City and more recently a regional task force that operates in Dublin County where drug prevalence may not have been as problematic historically. The task forces work with Government to integrate local drug strategies into the programme for government.
- Community Drugs Teams - Community Drugs Teams (CDTs) are locally based and often operate alongside Outreach Workers. CDTs are involved in numerous projects, often with an education/prevention focus, but understanding of their function and links in to the wider system are patchy. The activities of CDTs vary across localities, with some CDTs running drop in centres, such as the Mountview/Blaketown CDT. However, all CDTs ostensibly provide links to other services for drug users meaning there may be some scope to consider utilising this staff group wholly, or partly, as care - coordinators.

Consideration should be given to the integration of the work of all the above services into the proposed locality team model (see Figure 3)

- Alcohol - There are currently very limited and ad-hoc services for alcohol misuse and almost all staff groups reported having some informal association with alcohol misusers. The Stanhope Centre provides some alcohol education sessions but this is limited and difficult to access, especially for those on methadone maintenance. Some alcohol detoxification is placed in residential units such as the Dublin Simon Community (11 beds) and there are some limited local alcohol counselling services. Links between alcohol misuse services and drug services are currently very unclear and some alcohol detoxification takes place in acute and psychiatric settings but is not always linked in to

the wider treatment system. The provision of alcohol (and other drug misuse such as stimulant misuse) should be integrated into locality teams as set out below. This should allow for the development of evidence based community assisted withdrawal.

Appendix 5: Cost

Example Service Costing (London Borough of Camden)

The tables below are intended to be illustrative only and do not aim to show that a reduction in funding for the addictions service in Dublin North City and County is required. It is recognised that funding, costs, systems and policy in Ireland differ significantly from that in the UK. Instead the section below is to demonstrate that the service is well resourced and should be able to implement the recommendations contained in this report within the existing financial envelope.

Camden has a population of about 220,300 compared to Dublin North City and County with a population of just under 579,447. Camden is a useful comparator as an inner city borough with high crime rates, poverty, and availability of relevant data. Figures for the service include all funding for drug and alcohol treatment including that provided in primary care. There is no parallel funding for primary care provision.

The service has approximately 4328 Problematic Drug Users (PDU's) in treatment, of whom 3699 are using opiates and 3084 are using crack. Polydrug use is common, usually crack and heroin alongside alcohol, benzodiazepines and cannabis.

Table 1 below uses this information to show what this might mean if these numbers are extrapolated to Dublin North City and County and is not describing current provision and cost. Table

1 is calculated by taking the number of people identified as PDUs in Camden, and extrapolating to develop an indication of need in Dublin North City and County .

Table 1: Prevalence of Problem Drug Users (PDUs) and alcohol misusers in Camden extrapolated to Dublin North City and County

	Camden	Dublin North City and County (extrapolated data)
Population	220,300	579,447
PDU	4328	11,357
Opiate PDU	3699	6,837
Crack PDU	3084	8,112
Polydrug PDU	2455	6,431
Dependent and Harmful Alcohol*	11,289	29,667
Need**	15,617	41,024

* People drinking at levels of higher risk of harm - this equates to men drinking over 50 units per week and over 35 units a week for women

**A sum of PDU plus alcohol

Table 2 shows the number of people actually receiving treatment in Camden and extrapolates those figures as a comparator for Dublin North City and County (it should be noted that typically the majority of problem drug users are not in treatment at any one time).

Table 2: Problem Drug Users (PDUs) and alcohol misusers in treatment in Camden extrapolated to Dublin North City and County

Treatment	Camden	Dublin North City and County
Total PDU	4328	11,357
PDU in treatment	1732	4,543
PDU drop out*	388	1,018
Alcohol**	700.0	1,839
Need***	2,432	6,382

* Meaning those in treatment in 2007/8 and dropping out of treatment and not returning in 2008/9)

** Receiving structured treatment for alcohol misuse

*** Sum of PDU numbers in treatment and Alcohol numbers in treatment

Table 3 looks at the total cost of substance misuse treatment in Camden against that of Dublin North City and County. It should be noted that costs for the Dublin North City and County Addiction Service do not include funding for the voluntary sector as this is not funded by the HSE.

It is recognised that funding and costs in Ireland differ from the UK but this still serves as a useful starting point for an estimate of the likely resources needed for the effective treatment of drug misuse in Dublin North City and County . The Camden spend includes services for alcohol although it should be noted that they are more limited than the those services for drug misuse. Cost is based on Camden spend on substance misuse in 2008/9** which was £5,300,000. Accounting for inflation at 8%, this equates to about €7,110,000 which is the currency shown in the table below.

Table 3: Treatment Costs in Camden and Extrapolated treatment costs for Dublin North City and County

	Camden	Dublin North City and County
Population	220,300	579,447
PDU in treatment	1732	4542
Actual Spend (€)	7,110,000	22,000,000
Extrapolated Spend (€)	7,110,000	18,644,910

** <http://www.camden.nhs.uk/downloads/Operating%20Plan%202009-2010.pdf>

As can be seen from Table 3 the current spend in Dublin North City and County is around €3.3 million over that spent in Camden for treating a broadly equivalent number of service users (1732 in Camden 4542 in Dublin North City and County) but in reality only 1854 service users are in treatment in Dublin with an additional 1009 receiving some support in primary care, This suggests potentially significant over-resourcing of the existing service in Dublin. Some caution is needed in the interpretation of these figures as the Camden costs (for a well- developed service) are based on an extrapolation from 2008/2009 funding, include a broader range of drug misuse than opiates alone and include the vast majority of drug services funding whereas the Dublin costs do not include the costs of the significant input from the voluntary sector or that provided by primary care based GPs.

Summary of Estimated Needs and Cost (Drug Extrapolation)

- The data from Camden suggests that around 4542 people could be expected to be treated for drug misuse in any given year against the actual number in treatment which is 1854 (with a further 1009 receiving some support).
- An equivalent, extrapolated total cost of treatment could be expected to be around €18,644,910 to treat 4542 people, based on Camden. This is against an actual total cost of treatment of €22,000,000 to treat 1854 (plus 1009). Dublin North City and County might also expect to treat around 1839 people for alcohol misuse and the above figures suggest that this should be possible within the existing budget.
- Extrapolated costs shown in table 3 illustrates that Dublin North City and County Addiction Service costs around €3,355,000 more than the Camden equivalent.