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REVIEW OF DRUG SERVICES

IN THE

EASTERN HEALTH BOARD AREA

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EXECUTIVE SUMMARY

1. The authors have a broad background in practical and policy aspects of drug services and have conducted a brief initial review of drug services at the request of the Eastern Health Board. Their interest in inviting an external critical review of their services and their openness in discussion on the problems and difficulties facing service development has been impressive.
2. Drug misuse is a complex psychosocial problem that requires a multifaceted response. There is no single or simple solution to such problems and there is a need to regularly review and modify responses to problems to aim to achieve efficient and cost effective services.
3. Overall the Eastern Health Board has achieved an impressive range of goals to date with the establishment of a network of services and a rapid growth in its overall size of service provision. Such growth levels provide particular challenges in their management and the ongoing level of growth continues to place this type of service under continuing pressure. The range and pattern of service provision is consistent with most and further advanced than many other European Union member states. The Eastern Health Board has achieved major milestones in the development of a wider network of drug services. There is now a wide range of treatment options available ranging from drug free therapeutic communities, drug free counselling, in patient detoxification to methadone substitution and methadone maintenance to needle exchange and outreach services. There is also a strong voluntary and community organisation voice to complement and support the statutory sector input.
4. There is reasonable evidence that treatment interventions provide a high level of return immediately for money spent. In two separate large econometric studies in the United States it was estimated that for every pound spent on treatment there was a £7 saving and the largest savings are due to reduction in criminal activity.
5. The establishment within the past year of a Eastern Regional coordination group and an Eastern Health Board strategy group with wide service and community involvement is critical to the future development of the services.
6. There is a need for clarity for functioning and responsibility among the key service providers. For this purpose the division of the service area into three sectors with each sector having key identified providers should assist in an appropriate division of labour and in the effective coordination of these services.
7. There is a need for a range of epidemiological data that can assist in the longer term steering of services to ensure that the appropriate mix of services is provided based on the evidence for their effectiveness and the evidence for their need in the community.

8. There is a need to further develop a system of monitoring and evaluation if the long term activity is to be justified on cost grounds. A longer term outcome study of a range of treatment interventions should be considered.
9. The effectiveness of the service and the efficiency of these services needs to be continually monitored in the context of new information on approaches to treatment and some knowledge about what would be considered a reasonable level of performance. There is a need to develop a range of performance standards and outcome measures to assist in future service development.
10. The move to involve primary care in the provision of services is an important long term strategic goal and needs to be adequately supported and developed if it is to be successful. Such a move is critical to the long term success in developing these services. Support should be provided for training of general practitioners in the management of substance misuse problems in primary care with a view to improving levels of skills and knowledge across a range of substance problems.
11. There are approximately 50 methadone maintenance places per 100,000 population at present in Dublin the inclusion of general practitioners increases this substantially. In a review of services in 1993 the highest level of provision was 100 treatment places per 100,000 population to 1 treatment place per 100,000 population. There is considerable variation in the mode of delivery, with the majority delivering on-site methadone maintenance with associated primary care involvement. In balancing capacity and distribution there is a need to explore the balance between on-site methadone maintenance and off-site methadone maintenance.
12. There is an urgent need to address the capacity problems facing the methadone maintenance service. Considerable steps have been taken by the Eastern Health Board drug services to address this. These approaches need to be supported and developed. The establishment of an interim methadone programme using mobile facilities should also add to service flexibility.

There is a need to explore the possibility of increasing the capacity of the individual programmes. The current operational costs per individual per year of approximately £2000, appear reasonable by international standards where the individual cost ranges from 1500 to 4000 pounds per person per year. In different countries in some services the key workers have 30-50 cases each but others have key worker ratios of 10 to 1.

14. The outreach and needle exchange services should be reviewed to ensure service growth and change as the other services expand and develop.
15. The growth in general practice and pharmacy activity should be surveyed and such a survey repeated in the future to determine the impact of the strategy on general practitioner and pharmacy activity.
16. There has been substantial development in the provision of inpatient detoxification. It is desirable for units to run a minimum of fifteen beds for cost

effectiveness purposes. A significant number of users of in patient detoxification go on to residential rehabilitation facilities and overall there is a need to look at the articulation between the provision of in-patient facilities and residential treatment facilities and day care facilities. The average provision of these facilities appears to range between 0.5 and 1.5 per hundred thousand adult population. By international standards this is a good level of provision of an expensive service.

17. There is a high levels of day programme provision and some particularly innovative approaches have been developed that merit further evaluation. The links between these programmes and other activities could be enhanced.
18. The liaison mechanisms of the different services could be enhanced and there is a need for major prioritisation of service input and liaison with the prison service and other aspects of the criminal justice system. Liaison with HIV and general psychiatric as well as alcohol services needs to be further developed. The current appointment of new consultant psychiatrists and the development of the regional coordinating group should assist this process.
19. The Eastern Health Board has gained substantial experience in community consultation through the service development to date. Community consultation will remain a high priority activity as the current phase of service expansion takes place.
20. The long term strategy should be to develop an integrated alcohol and drug service with highly skilled primary care and community based service providers with specialist back up services involved in an ongoing development and change in approaches to the treatment of addiction problems.

1. INTRODUCTION

- 1.1 Drug misuse is a complex psychosocial problem that requires a multifaceted response. There is no single or simple solution to such problems and there is a need to regularly review and modify responses to problems to aim to achieve efficient and cost effective services. Each country is unique and its responses are tailored to particular local circumstances. However the drug problem is an international problem and there is a considerable range of experience and evaluation of interventions which are mainly descriptive outcome studies rather than studies with an experimental design. There is a need to interpret such information with considerable caution but with limited local evaluation data available to date, the international research provides some guidelines on empirically derived approaches to treatment and rehabilitation. Such existing information can be particularly useful in the process of formulating approaches to the evaluation of services. The Eastern Health Board services for drug misuse have undergone rapid expansion in the past three years and continue to expand and there is a high level of executive and Board support for the development of these services. In the context of this rapid development it is useful to review such developments and assess their comparability with developments in other countries where possible. This present report has been commissioned for that purpose and the terms of reference are:

2. TERMS OF REFERENCE

The terms of reference agreed between the Eastern Health Board and the evaluators are as follows:-

"having regard to the national policies within which services are provided

- 2.1 To review the evolution of current policies and practice in relation to the provision of services for drug users (focusing on opiate users) in the Eastern Health Board area with particular reference to services directly provided by the Eastern Health Board.
- 2.2 In carrying out this review to take appropriate account of service responses from non-government organisations, other state agencies, general practitioners, hospital services, with particular reference to the coordination of these services with directly provided health board services.
- 2.3 In carrying out this review to take account also of mechanisms for consultation with and gaining support of local community interests.
- 2.4 To comment on the service responses in the Eastern Health Board area in the context of trends and practices elsewhere."

3. METHODS

- 3.1 This involved discussion with policy makers, officials, and key service providers and brief visits to some of the services over 5 working days by the two evaluators. Key documents have been read. The time scale from project initiation to completion was one month. By definition this is a rapid assessment project and aims to provide a brief overview rather than an in depth analysis. It was agreed that in the course of the review that specific issues that were identified would be explored in greater detail later.

4. EVOLUTION OF CURRENT POLICIES AND PRACTICE

- 4.1 As in many other European countries Ireland remained essentially free of a substantial illicit drug problem up until and during much of the 1960's. The rapid development of problems in the 1960s resulted in the recommendation that a specialised service be established. A permanent advisory body known as the Interdepartmental Committee on Drug Abuse was established with representatives from the treatment, police and pharmaceutical bodies based at the Department of Health met from 1972-1982 and advised the Health Minister on the changing drugs scene.

- 2 In the mid 60s there was concern about the misuse of amphetamines and in the early 70's a small opiate problem developed and there was a considerable growth in cannabis and LSD use. There was a dramatic change in the late '70's with the very evident heroin epidemic and high levels of injecting use of other prescribed opiates such as palfium and diconal. Jervis Street Hospital reported a dramatic rise in referral for treatment in the late seventies and early eighties. On the basis of first treatment contacts it was estimated that there were 3,000 opiate users in Dublin. A community drug study conducted by the then Medico-Social Research Board indicated pockets of very high heroin addiction among inner city community groups with the reporting of 10% of the 15-24 year old age group involved in heroin use. This study resulted in the development of a special governmental task force on drug abuse which resulted in legislative changes.

About the mid 1980's local activism among parent and community groups in the localities most severely affected by the drug problem resulted in major tension and high profile vigilante tactics directed at individual drug users; It was estimated the opiates addicts were mainly concentrated in Dublin and were frequently concentrated in small localities with high levels of socio-economic deprivation. Despite evidence of illicit drugs such as cannabis and ecstasy in other parts of the country to date the number of opiate users reported outside Dublin remains in the two figure region.

The predominant route of heroin use is injecting however there are reports now of significant changes with the growth of a heroin smoking population and there is a need for services to adapt to this demographic shift. There are no reports of significant levels of cocaine in Dublin but most other major European cities

Throughout the 70s and 80s these two services constituted the entire drug service for Ireland. In the late 1980s the National Drug Advice and Treatment Centre moved to Trinity Court into purpose built facilities and expanded its range of activities. The inpatient service also moved to Beaumont Hospital and is a 10 bedded detoxification unit. A number of addiction counsellors were appointed to some of the community care teams and these became team members in a larger generic multidisciplinary team. A voluntary sector street agency response grew in the mid eighties and aimed to provide advice and counselling with a focus on health promotion and harm reduction. This sector was a strong voice for change and service development.

5.2 The Government Strategy to Prevent Drug Misuse (1991) gave responsibility for the provision, coordination and funding of treatment programmes for drug misusers to the Eastern Health Board in respect of Dublin, Wicklow and Kildare. The exception was the Drug Treatment Centre at Trinity Court which is funded directly by the Department of Health.

5.3 As a result of the severe capacity problems and the identified numbers of HIV positive injectors the Eastern Health Board established a drug service under the management of the public health service and was run in conjunction with other HIV related services. This service started as a low threshold low dose harm reduction and methadone dispensing service but subsequently established a methadone maintenance service in Baggot Street in 1992 with the aim of working closely with primary care services. Subsequently in 1993 two other satellite services were established in the North Inner City and in Ballyfermot with the aim of providing methadone maintenance services. To gain and maintain community support for these community drug centres they have had to be designated as catchment area services that specifically service those from the catchment area and do not import drug users from other areas.

5.4 There has been a dramatic increase since the late 1980's in the levels of service provision and it is now estimated that there were an estimated 2,700 persons treated for drug problems of whom 80% were opiate users in all the services. Each clinic appears to have an operational capacity for methadone maintenance between 150 and 200 places allowing for a total of 700-800 places. It is estimated that general practitioners prescribe for over 500 persons in a mixture of private and general medical service settings. In the past there have been reports of epidemics of morphine sulphate continuous and other types of opiate substitutes problems resulting from primary care prescribing and wholesale and retail pharmacy thefts. The control mechanisms for addressing irresponsible prescribing are slow and due to the judicial nature of the activity cumbersome and need the full backing of the body of general practitioners to ensure ongoing good relations with them. The clinics provide a low threshold programme with associated harm reduction advice and a methadone maintenance programme. The past five years have seen substitute prescribing become the dominant form of treatment intervention of the opiate addicted individual. However there are over 500 individuals who are long term injecting drug users awaiting treatment. As well as this development in methadone maintenance services there has been a substantial growth in...

maintained individuals and some other voluntary sector projects. The Government's strategy to prevent drug misuse states explicitly "in the case of medical treatment of drug misuse the Government recognise the important role of the primary health care doctor. In considering the medical treatment of drug misusers, the Government have based their strategy loosely on the model which exists in the treatment of acute medical and surgical conditions whereby the patient is referred to a consultant for specialist assessment and treatment following which he/she is returned to the care of the general practitioner for ongoing treatment and monitoring. While recognising their fundamental differences it is felt that this model should be filled as far as possible in the case of drug misusers. It is proposed that the specialist services conduct an initial assessment but that GP's continue the ongoing care with support from community services".

The Department of Health with drug specialists and some leading general practitioners have drawn up a protocol for the management of drug users in primary care (Expert Group 1993) and at the time of the visit plans by the Eastern Health Board were at an advanced stage for the transfer of a hundred individuals from the specialist services to primary care. This is part of a general strategy to move stabilised addicts from specialist services to primary care and is critically contingent upon the willingness of general practitioners to partake in such a programme. There appears to be a number of general practitioners prepared to develop this and an evaluation project should further support this development.

5.5 A new in-patient detoxification unit was established in 1995 in Cherry Orchard by the Eastern Health Board and the need for a downstream residential facility was recognised as a potentially important way to maximise on the utilisation of the detoxification unit. The Merchants Quay Project is establishing a residential programme in facilities made available to them and the proposals for the funding and for the operational policies for this residential programme are currently in the process of being developed.

5.6 The directory of services for the area recently published by the Eastern Health Board outlines a wide network of community based services many of which are generic services.

By September 1995 the Eastern Health Board was employing 114 full time, 6 part time and 12 sessional staff.

5.7 Along with the statutory sector development there has been substantial growth in the voluntary sector with a number of strong organisations both in the specialist area of drug services but also as part of broader community groups. As the services expand there is a need to foster and secure the stronger organisations. Such organisations have an important role to play in the development of direct and alternative access services and also have more flexibility in developing one off and innovative projects.

report a significant growth in cocaine use among its addict population and it would seem reasonable to plan for some growth in this problem.

- 4.5 The Health Research Board has been active in the Pompidou group and have participated in the multi-city study of first treatment demand. The multi-city report indicates that first demand for treatment rose steeply in the early eighties and then declined steadily but has risen significantly again. A first treatment demand reporting system in 1994 covered 15 treatment centres. The number first treatment contacts has substantially increased from 859 in 1993 to 1150 in 1994. Over 80% report opiates as primary drug of misuse and a significant proportion fall into the early age of 15 to 19 with this group being approximately twice as likely to smoke than inject according to the Health Research Board report of 1995. However this data needs to be interpreted cautiously particularly in the context of the large waiting lists for services. Detailed data on prisons are not available.

4.6 OTHER INDICATORS OF THE DRUG PROBLEM

Up to September 1995 there have been 259 deaths from AIDS, the cumulative total of AIDS cases is 491 with 212 (43%) being injecting drug users. Of those who have tested positive by August 1995 there were 1,589 of whom 769 were intravenous drug users, which amounts to 48% of the total and suggests a levelling off of HIV seroconversion among injecting drug users. It is clear that the problem of HIV and AIDS among the injecting drug using population was the initial priority for responding to drug problems within the Irish and in particular within the Dublin setting. This type of HIV generated response occurred in most EU member states and the policy imperative has moved to a broader concern about all aspects of drug misuse with a particular concern about the links between drug misuse and crime, and community safety and community well being.

The estimate of HIV infection rates among new presenters to the services is about 8% but hepatitis C figures are reported between 50-70%.

There is limited data on drug related deaths but a brief visit to the Dublin City Coroners court indicated that there are one to two addict deaths per week, a reasonable estimate is that 1-2% of the opiate addict population die each year and this is reduced to approximately 0.25% for those in treatment but is also complicated by the high prevalence of HIV and AIDS among the treatment group. There is a need to quantify and monitor all addict deaths and to proactively gather data on opiate addict deaths.

DEVELOPMENT OF DRUG SERVICES AND CURRENT SERVICE PROVISION

- 1 The first specialist drug service was established at Jervis Street Hospital in 1969 and was run as an out patient service. A separate small inpatient service combining alcohol and drug problems was established. In 1973 a drug free therapeutic community, Coolmine Therapeutic Community, was established

5. OVERVIEW OF CURRENT ORGANISATION AND SERVICE PROVISION

5.1 Overall the Eastern Health Board has achieved an impressive range of goals to date with the establishment of a network of services and a rapid growth in its overall size of service provision. Such growth levels provide particular challenges in their management and the ongoing level of growth continues to place this type of service under continuing pressure. There has been limited opportunity for consolidation in the face of ongoing change. We were informed of proposals already in train to strengthen the management of the service in response to recent and projected growth. The range and pattern of service is consistent with most other European Union member states.

2 To date the development of services has been demand led in response to the need of the long term opiate addict population. There is a need for community epidemiological studies to establish the nature and size of the target population and to ensure that an adequate balance is achieved in responding to populations with differing needs in particular young people who are at an earlier stage of involvement with drugs misuse. Need should be defined as ability to benefit from the service supplied and should be shaped by available knowledge on the effectiveness of different interventions. To date this is one of the justifications in many countries for the investment in methadone maintenance. The demand and problems generated may not exactly match the assessment of need.

Approaches could include a capture-recapture study to estimate the size of the injecting or addicted population, conducting household surveys or the incorporation of questions on drug use into other general surveys. The development of a school survey that could be conducted on a biannual basis.

MONITORING AND EVALUATION

There is a need to further develop existing monitoring mechanisms for all services funded through public bodies so as to ensure adequate accountability. Firstly there is a need to adequately define the population being treated and to provide a good description of the physical, psychological and social burden they present to themselves, their families and the broader community. There is also a need to conduct measurement of service impact on drug using behaviour, physical and psychological health, and on offending behaviour. The longer term funding viability of these services is based on their capacity to demonstrate their ability to impact positively on physical, psychological and social dimensions of the service users. This is not an easy task but such information can provide critical data for the change and development of operational policy to ensure its grasp of its own performance and capacity to adapt to changing circumstances.

A descriptive outcome study covering a range of treatment modalities would provide information on the characteristics of the different treatment population and the outcome from such treatment. There is also a possibility of conducting some more experimental studies but the initial stage should be to conduct some modest outcome studies.

The establishment of a Strategy Group led by a Director of Drug Services (in place of the former AIDS/Drugs Co-ordinator post) should assist in the achievement of an appropriate balance between demand and supply of services. The process of monitoring and evaluation and measurement of service outcomes will be brought forward by this group as a core part of the strategic development of services.

6.4.1 CO-ORDINATION

The size of the Eastern Health Board Area and the compact size of Dublin city and the overall human resources and financial resources available offers distinctive and concrete possibilities of seriously impacting on the overall drug problem over the next three to five years. A coherent coordinated strategy that is monitored and adapted to varying sectoral performances is critical to this. Drug services in most countries particularly during the early phase of development have been divided and oppositional by nature. This partly reflects the complexity of the population being served and the limitations of the interventions available. Because of the complex nature of the service there is a need for highly organised coordination systems to ensure efficient service delivery. Because of the multiagency nature of drug services good coordination and liaison and consultation mechanisms are essential and considerable progress has been made in this direction by the Eastern Health Board.

4.2 To date the role of the Eastern Health Board AIDS/Drugs Co-ordinator has been well established and was positively commented on by many of the individuals and groups interviewed. The coordination process will be continued under the new Strategy group arrangements. This is important in the context of the need to separate responsibilities for operational management of services from strategic functions such as the planning monitoring evaluation and co-ordination of services. It is particularly important where contracting for services with the voluntary sector is involved that the standards required from directly operated services are the same in terms of efficiency, cost effectiveness and quality, as those required from the voluntary sector. This will be facilitated by the new Director of Drug Services who will not be involved in operational management.

The establishment of the Eastern Regional Co-ordinating Committee on Drug Misuse in May 1995 with representation from relevant statutory and voluntary agencies and community groups has enhanced service planning and co-ordination. The recommendations of the sub-committees on treatment and prevention respectively form a concise and comprehensive multi-sectoral summary of the current problems and needs of the services.

The current appointment of 2 new full time Consultant Psychiatrist will facilitate a move towards sectorisation and this will further improve the co-ordination of services. Three sectors are proposed within which local needs will be addressed through a co-ordinated response by statutory and voluntary providers and community groups.

6.5 SPECIFIC SERVICES AND ISSUES

6.5.1 There is now a wide network of services available and there is strong community voices available to shape and assist in future developments. In a short period of time a major change in service provision has been successfully executed. The expansion in provision of methadone and the emphasis on this aspect is consistent with other countries. The use of on-site dispensing clinics are similar to most countries except the UK where general practitioners and community pharmacists have also played a significant role but this varies by region and locality. The policy of having a mixture of specialised community drug services and primary care services is similar to many other EU member states.

6.5.2 WAITING LISTS

The waiting list for methadone treatment is a major cause for concern for individual and communities and organisations for a variety of reasons

- drug users awaiting admission are involved in higher levels of HIV and injecting risk taking behaviour, much higher levels of criminal and offending behaviour, higher levels of community disturbance including drug use and drug bartering, higher levels of overdose and death rates, higher levels of consumption of non-supervised methadone consumption and making demands and exhortations on current service users to divert or sell their methadone thus reducing the compliance and efficacy of those in treatment.
- such drug users make inappropriate demands on primary care services and potentially alienate general practitioners from any involvement with drug users.
- Individuals, parents, neighbourhoods and other organisations perceive the drug services as failing in their task and interpret it as a sign of inadequate government responses to the drug problem.
- it stimulates organisations (both governmental and voluntary) to come up with ad hoc proposals which are not coordinated with other initiatives.
- complaints articulated through the media continue to highlight the problem as an issue of major social and political concern and overall this tends to undermine efforts by the services to communicate the achievements to date in service development.

6.5.3 RESPONDING TO THIS PROBLEM

To tackle the methadone maintenance waiting lists the Eastern Health Board proposes to

- a) extend the opening hours of two of the clinics

- b) recruit additional addiction counsellors and outreach workers to provide support to general practitioners
- c) the introduction of special arrangements to deal with crises cases

The strategy for involving general practitioners is the correct long term strategy but there are problems with the adequacy of general practitioner provision in some localities particularly some of those with high levels of drug problems. In some such localities the development of primary care centres or general practitioners with a major interest in substance misuse problems might be considered. General practitioners have a major role to play in their contact with families and the broader community. However the task of involving general practitioners started a number of years ago and is a slow process which requires substantial support which and appears to have been strategically well developed between general practitioners and specialist drug service practitioners with proposals to further develop

- a central prescribing register for controlled drugs, including the use of a treatment card, in the treatment of addiction to reduce double prescribing
- a clear protocol
- a reimbursement system
- cooperation of community pharmacists to dispense methadone (in the medium term this should also include exploration of pharmacists involvement in supervised dispensing)
- investment in support and training for general practitioners.

Most of these activities are in progress. Progress on these could be usefully fed back to the strategy group and the regional coordinating committee.

The involvement of prominent general practitioners from at least two of the medical schools is an important long term dimension for the future development of substance misuse services in primary care. The Eastern Health Board should consider a brief questionnaire postal survey of all or a representative sample of general practitioners to determine a baseline level of activity of general practitioners. Such a survey could be repeated in two to three years to determine levels of change. Similar baseline measures of knowledge and attitudes among community pharmacists should also be considered.

5.4 The expansion of services through primary care are a longer term strategy and need to be complemented by a more immediate mechanism to expand methadone provision which should include

- establishing new community drug centres
- further exploration of ways to increase the capacity of existing clinics through an operational review of staff and team functions activities

approximately £2000, allowing for labour costs appear reasonable by international standards where in a study of methadone programmes in the European Union the individual cost ranges from £1500 to £4000 pounds per person per year. In that study it was reported by Farrell et al (1996) that some services have key workers with a 30-50 client case load each but others have key worker case loads of 10 clients each. The human resource cost of urine monitoring should be reviewed. Procedures to streamline methadone dispensing should be explored and consideration should be given to piloting an automated methadone dispenser at one community treatment centre.

starting a new interim methadone programme using a mobile bus which has already been converted by the Eastern Health Board for this purpose and is available for immediate use.

This programme should clearly be an interim programme which means that it should be time limited (possibly two years) and that the care offered is limited per patient, working towards referral to either a satellite clinic or a general practitioner. This service should operate 7 days a week with no take home facilities. Clients should be assessed for it in a separate fixed site. Counselling should be limited and opening hours should be limited. This mobile bus could be flexible and serving various neighbourhoods limiting time there to one hour and dealing with a maximum of 40 clients per location. Consideration should be given to one of the sites being Dr Steeven's hospital for public relations purposes. Special attention should be given to issues of security of the personnel and the logistics surrounding the handling of the methadone.

DETOXIFICATION

The provision of shorter term interventions such as lofexidine detoxifications and methadone reduction for the shorter term users and the capacity for more rapid response to users at an early stage in their career needs to be considered and the development of links between such interventions and the community based rehabilitation programmes should be enhanced. Such detoxification services should be part of the overall community service provision and should be in a continuum with the methadone maintenance programmes. However it is advisable that at least one community team develop a protocol and establish a pilot project with rapid access for community based lofexidine detoxification. This is consistent with the present aim of moving stabilised drug users to primary care and to enhancing general practitioners skills in the area of managing people with substance misuse problems. Overall there is a need to fine tune the balance between longer term and shorter term interventions.

IN-PATIENT DETOXIFICATION AND RESIDENTIAL SERVICES

The types of services provided fall well within the range of services covering from drug free therapeutic communities to street agencies to methadone maintenance services. In most countries the thrust of drug service development has been community based after an earlier phase of substantial residential sector development. Given the considerable investment in-patient

facilities in Dublin there is a need to further examine the possibility for further development in the residential drug service provision to expand choice in this area with the provision of a shorter stay treatment programme to complement the services of the longest established therapeutic community. The inpatient facility needs to be expanded to a minimum of fifteen beds if it is to be cost effectively run from bed to staff patient ratio. This service could also be used as acute crises and for assessment and stabilisation. Such functions could be divided between the Cherry Orchard and Beaumont facilities. Approaches to more rapid detoxification such as lofexidine and naltrexone should be further explored with the aim of reducing duration of inpatient stay. Longer term development should consider a combination of alcohol and drug detoxification services with a view to service diversification. The links with day programmes should also be further developed.

6.8 OUTREACH SERVICES

As the treatment services expand the role and requirements of the outreach services naturally change. There would be value in specifically reviewing the possibilities of enhancing the contribution of outreach services as part of the totality of drug service provision.

6.9 NEEDLE EXCHANGE PROGRAMMES

Given the HIV and drug situation in Dublin we were impressed with the establishment and provision of a network of Needle exchange programmes across the city. Overall we feel that there is a need for a review of the needle exchange facilities with a view to further expansion in provision. Specific issues that could be reviewed would be community reassurance regarding an emphasis on provision of disposal facilities for used equipment, issues of accessibility and opening hours, and overall hygiene and safety standards.

6.10 DAY PROGRAMMES

There has been a significant development in these services and the links with FAS make these services striking and somewhat unique in their organisation. The broad based approach associated with the possibility of payment for attendance has not been tried elsewhere to our knowledge and ideally should be comprehensively evaluated. There is a need to determine the cost effectiveness of such programmes and to explore whether it is possible to stratify such programmes so as to increase the range and volume of individuals involved. The potential for links with the methadone treatment programmes either as an integral part of the community drug treatment centre activity or as sub activity of the day programme is apparently in the pipeline. Links with the inpatient detoxification units should also be developed further.

6.11 PRISONS

Prisons are now well recognised to have significant levels of drug availability and individuals in detention are at increased risk of contracting HIV, hepatitis B and C and other blood borne viruses as a result of increased risk taking

behaviour. In addition opiate dependent prisoners who become drug free during detention are at increased risk of overdose on discharge. Ensuring good links between community services and prison services for drug misusers needs to be an important part of the service development.

The current appointment of a consultant with specific prison sessions is a major resource investment in enhancing links between the prison and community services. However there is no infrastructure to support this senior level of input. There is a need to consider using some of the community drug workers as sessional input to the prison service so as to construct a prison drug team with good links to all three sectors of community services. One of the key tasks for this consultant will be to develop protocols and standards for treatment that would support the continuity of treatment services for persons entering and leaving prison.

The most popular form of prison treatment is that of the drug free therapeutic community and the possibility of developing such a facility should be further explored with key players who have an interest and experience in this area. Coolmine therapeutic community would appear to be the service in the best position to develop such an approach. The skills of some of the more recent day programmes may be of considerable relevance also.

Overall there should be considerable optimism about approaches to services in the prisons with the development of the consultant input and the provision of dedicated service resource directed at those going into and being released from prison makes it possible to seriously impact on the prison environment. Other prevention strategies need also to be adopted by the prison authorities to minimise the risk of blood borne disease transmission during custody.

6.12 LIAISON

The liaison function needs to be at the heart of the community based services. As the level of skill increases in primary care the role of specialist services will depend critically on how well it has developed its consultancy and liaison function. There is a need for liaison with primary care services, obstetric and family services, general psychiatric services, GUM and HIV services, prison services, hepatology services, probation and courts and other drug services. The liaison mechanisms with these different services should be part of a review of operational strategy and the establishment of an Operational Liaison Committee should be central to the further development of good liaison policy and operational procedures.

6.13 TRAINING

There are considerable difficulties in establishing reliable quality control measures in services that cover a complex range of health and social problems. However one critical measure of quality is the capacity of the service to ensure that the staff have the necessary skills and knowledge base to adequately perform the task and are properly motivated to do so. The diffuseness of the tasks makes a combination of in-service training and more enhanced training for individuals as part of the service development strategy.

clinical, technical and operational issues and may be focused on organisational and management issues depending on the present and future tasks of the staff. There is a need for a clear training strategy and a need to invest in the future quality of service. Such training should be practically based and directly relevant to the work tasks. There should be a specific budget allocated for training developments.

COMMUNITY CONSULTATION

- 7.1 The Eastern Health Board proposes to significantly expand services for drug users in their own local communities through a number of new initiatives:
- [i] through the development of a small number of additional community drug centres in order to provide significant geographic coverage
 - [ii] through significantly expanding the involvement of general practitioners in the treatment of drug users
 - [iii] through expanding the involvement of community pharmacists in the dispensing of methadone under controlled conditions
 - [iv] through the introduction of a mobile bus or clinic which will complement the other services listed above and which will be aimed at the more chaotic drug users
- 7.2 Community resistance to the establishment of services for drug services is an international phenomenon and is directly linked to the marginal social status of the service users. The Eastern Health Board has been involved in a considerable level of community consultation over the past three years and has successfully established and bedded down a number of community drug treatment centres. The successful experiences need to be built on as further services are developed. Local needs assessment projects that develop reliable estimates of the size of local problems should assist the communities in determining their commitment to appropriate local responses.
- 7.3 The Eastern Health Board decentralisation programme with a mixture of specialist and primary care services is attempting to disseminate services as broadly as possible. There is a need to communicate that the overall strategy aims to minimise congregation of users in small localities. The absence of services for local communities with significant drug problems gives rise to significant social and public health problems. The weight of evidence for the benefits of such services is strong and needs to be convincingly communicated to all interested parties. The community drug centres need to be identified as an important local resource with a broad role including the provision of advice and information, access to rehabilitation programmes and to support prevention, education and information programmes for parents, community groups and schools. A member of the strategy group has specific responsibility for community liaison and this should ensure effective communication in both directions.

- 7.4 The community voices in Dublin are coherent and impressive. There is a clear need to continue to work with and harness this voice in support of the further development of services. Consultation and liaison within well defined parameters and with a clear commitment to service development will bear fruit in due course.

The need for locally based services is a key aspect of the Eastern Health Board strategy. It is important that professionals, politicians, policy makers and the broader community understand the public health importance of such services and their overall value to the community. Community consultation needs to take place with a clear understanding that the needs of particularly needy and vulnerable individuals will be addressed and are not subject to a community veto on such service development and provision.

The needs and concerns of individuals and community groups need to be carefully heard and in particular such anxieties and concerns need to be monitored on an ongoing basis through a liaison group as the services become established. Issues arising within such liaison could be fed back to the strategy group through the individual responsible for community liaison.

CONCLUSION

The Eastern Health Board has achieved an impressive service development in the area of drug services since the early 1990s. There is now a network of services providing a wide range of options and serving a complex and needy population. The levels of provision of community based service and inpatient services are considerable but there is some geographic limitations due to community resistance to further service development. The proposed future developments and the high levels of commitment from all the key providers offer the possibility of consolidating on present gains and achieving a high level of impact on individuals and communities affected by drug problems over the next 3 to 5 years. The financial, human and skill resources are available and appropriate coordination, liaison and monitoring mechanism need to be put in place to ensure that this objective is achieved.

APPENDIX A

BRIEF OVERVIEW OF INTERNATIONAL LITERATURE ON TREATMENT FOR DRUG MISUSERS AND TRENDS AND PRACTICES IN OTHER COUNTRIES

1. There is a clear consensus in the international literature that there is no single treatment modality for drug misuse. The complex and heterogeneous nature of drug misuse problems and the different stages that individuals are at in their drug-using careers makes it essential that a wide range of interventions are available.
2. Overall the literature on comparative cost-effectiveness is weak. For this reason it is not possible to give indications of the best buy or value for money when comparing different treatment modalities. However, there is reasonable evidence that treatment interventions provide a high level of return immediately for money spent. In two separate large econometric studies in the United States it was estimated that for every pound spent on treatment there was a £7 saving and the largest savings are due to reduction in criminal activity. The long-term disruption of individual lives, disruption of families and the impact on children growing up in such families also form a long term burden and additive cost of human suffering.
3. The interventions reviewed below will be self-help networks, syringe exchange schemes, counselling, opiate detoxification programmes, methadone reduction programmes, methadone maintenance programmes, residential therapeutic communities, in-patient treatment based on the fact that these are the key modalities provided within the Eastern Health Board and also are the main modalities in which there is a literature available on the subject. The key players involved in such service delivery include specialist drug services, community based services including general practitioners, community welfare officers, community pharmacists, probationer officers.

4. A SELF-HELP NETWORKS

It is well recognised, particularly in the field of study of smoking cessation that the majority of people make several and serious attempts to change their own behaviour before seeking assistance. The complex interaction between self-initiated change and assisted change of behaviour need to be creatively worked with. Most heroin addicts presenting to services have made at least one attempt at self-detoxification. In consideration of this there is value in the provision of literature, booklets and information on the methods of self-detoxification directed at individuals and families. Such well-designed do-yourself construction booklets may have particular value for individuals at the early stage of their drug using or heroin addiction career.

Narcotics Anonymous is a large international self-help organisation based along the lines of Alcoholics Anonymous. There is a network of such services in Dublin and some limited evidence to suggest that use of Narcotics Anonymous

is associated with lower levels of drug use after leaving therapeutic communities.

Family self-help networks form an important part of community-based intervention and support but there is very limited literature on their effectiveness. Overall self-help networks involve minimal investment and are an important aspect of individual and community empowerment and should be fostered and developed by all means possible.

Peer support is now viewed as one of the more effective self help strategies and should be considered as a possible mechanism to foster self help networks. The development of professional support for such networks is necessary.

5. SYRINGE EXCHANGE SCHEMES

The central aim of syringe exchange schemes is to make sterile injecting equipment available to on-going injectors so as to minimise the hazards of injecting and to actively facilitate the safe disposal of injecting equipment. Exchange schemes may make contact with injectors who are not in contact with other services and the international literature consistently reports evidence of reduced sharing frequency among those attending exchange schemes. The presence of syringe exchange schemes does not appear to cause any increase in drug injecting. However, to date there is no evidence that exchange schemes have an impact on hepatitis C transmission and there is a need in the context of hepatitis C transmission to review further the possible methods for the prevention of hepatitis C transmission and the possible role of syringe exchange schemes. The potential for hepatitis B vaccination to be delivered through syringe exchange schemes in conjunction with primary care needs to be explored further. Overall syringe exchange schemes play an important role in the prevention of HIV transmission and the potential access point to a wider network of services.

6. OPIATE DETOXIFICATION PROGRAMMES

Opiate detoxification should be seen in the context of a broader treatment approach and not as a stand-alone intervention. Completion rates for in-patient detoxification are estimated at around 80% compared to less than 20% rate in the community setting. However, the volume capacity of the community setting may result in a larger number of actual completed detoxification and also provides a useful filter for in-patient services. Relapse rates are high and continuing relapse should be used to help the patient or client to set realistic treatment goals.

New agents and new strategies for detoxification are being developed and drugs such as Lofexidine may be an attractive non-opiate detoxification agent for use in the community drug team and primary care setting.

7. METHADONE REDUCTION PROGRAMMES

Methadone is frequently used in a gradually tapering dose method and is based on a motivation to achieve abstinence in the medium term, that is in two to six

months. Such interventions provide immediate benefit in reduction in drug use and injecting behaviour. There is reasonable evidence of the benefit in the short term but relapse to heroin use is frequent and may be linked to tapering methadone doses. Such tapering time limited intervention is attractive in the primary care setting because of the time limited nature of the intervention and a clearly defined goal of abstinence in the medium term of two to six months. Similarly the opportunity to link such a programmes with a different sort of day care and support interventions may enhance the outcome, but there is no good evidence to support this.

METHADONE MAINTENANCE PROGRAMMES

Methadone maintenance is the most evaluated form of treatment in the management of heroin addiction. There is clear and consistent international evidence that this form of treatment achieves significant reductions in heroin use and crime and a lowered risk of premature death including from overdose. The consistent finding is that a daily methadone dose over 50 mg is associated with lower rates of heroin use. Methadone maintenance has been found to be effective in reducing the spread of HIV through intravenous drug misuse and receipt of counselling and length of time in methadone treatment are both factors associated with a more favourable outcome.

Methadone maintenance programmes in a population with high levels of heroin addiction is justified as a major modality of treatment intervention. The level of methadone maintenance provision varies considerably internationally. In a review of services 1993 the highest level of provision was 100 treatment places per 100,000 population to one treatment place per 100,000 population. These levels are calculated for total national population and are not done for individual cities. There is considerable variation in the mode of delivery, with the majority delivering on-site methadone maintenance. However, in balancing capacity and distribution there is a need to explore the balance between on-site methadone maintenance and off-site methadone maintenance. One significant study in Glasgow reported on primary care delivered methadone maintenance without outcome levels comparable with those of international standards. Recently the Health Authority in Manchester established one thousand methadone maintenance places to respond to a long waiting list for treatment (the approach to this may merit further examination). Overall there is three possibilities for methadone dispensing on site supervised dispensing, off site community pharmacy supervised consumption and off site community pharmacy take home doses.

In the context of maintenance prescribing there are future possibilities with the use of other opiate type drugs such as buprenorphine and also LAAM. The potential attraction of these agents for on-site dispensing is that there are reports that LAAM in particular can be dispensed every two to three days compared to the daily dispensing of methadone. There are also suggestions that buprenorphine can be dispensed on a less than daily basis. The key variables associated with quality of methadone treatment and the quality of leadership and management within the service, the comprehensiveness of service intervention including medical psychological and social interventions. The dosage of methadone delivered within an appropriate range between 50 and 100 mg daily

is an optimum daily dose. The quality of counselling and other psycho-social rehabilitation has a significant impact on overall outcome of such treatment. One study of a day programme activity associated with methadone treatment reported significant differences in the levels of cocaine consumption with the day programme group consuming less.

There have been a number of waiting list studies and studies of interim methadone maintenance - that is where methadone is provided to those on waiting lists with minimal other intervention until the gain entry to the full programme. These studies show that interim methadone can play substantially more benefit than no methadone or waiting list control and confers less benefit than an enhanced methadone maintenance intervention. There is a need overall to find a balance between the quality and comprehensiveness of the input and the overall demand for service. Long waiting lists and non-response of services erode staff morale and contribute to a significant reduction in quality of service input.

There is very limited international evidence on the issue of the diversion of methadone. Levels of diversion occur in all countries involved in methadone prescribing and even the most tightly regulated system experiences diversion. Estimates of the amount diverted are not available. A potentially significant source of diverted methadone is that from users gaining multiple prescriptions and high dose prescriptions privately from general practitioners, while a significant number of treatment attenders will have sold methadone at some stage. The numbers involved in regular sale are estimated to be less than 10%. The two most common reasons given for these sales were to make money, often to buy other drugs and to provide methadone to a drug user not in treatment or to a friend who needed it. Regular or continued diversion of methadone is associated with three factors:

- 1) continued drug use of heroin or other drugs by patients,
- 2) the need to supplement income,
- 3) the desire to share with or sell diverted methadone to an addicted friend, and
- 4) to pay for private treatment.

The buyers of street methadone are likely to be those who are unable or unwilling to enter treatment. The substantial expansion of the availability of methadone treatment should have a considerable impact on the demand for illicit or diverted methadone by providing legitimate channels and treatment options for those desiring this treatment. The consequence of methadone diversion seems limited in that available information suggests that diverted methadone pays a small part in the overall drug crime problem and receives a low priority in law enforcement efforts. However, methadone may be dangerous and may be associated with overdose deaths. This may particularly occur in those who lack tolerance to opiates. The number of methadone related deaths increases as the level of methadone provision increases, but this may simply be a consequence of enrolling a large number of people on treatment. There is also some evidence that those dying of methadone related deaths are much more likely to be in receipt of diverted methadone, and that those in methadone treatment programmes have radically reduced mortality rates compared to those

out of treatment. Overall there is not much data on this topic but a difficult balance needs to be found between developing a comprehensive and accessible methadone treatment service which effectively reduces health and social harm associated with heroin addiction and maintaining adequate control and supervision of the delivery of that treatment to minimise negative consequences.

THERAPEUTIC COMMUNITIES

In the international literature residential treatment programmes can be usefully divided into three broad categories:

- 1) therapeutic communities
- 2) 12 step models based on Narcotics Anonymous and Alcoholics anonymous
- 3) more general houses some with a religious based philosophy such as Christian or Buddhist houses.

The international evidence including the CALDATA study from California reports that these services are cost effective simply by their capacity to eliminate drug use and criminal behaviour during the period of residence, irrespective of the longer term outcome. When longer term outcomes are compared with those clients receiving no treatment, improvements at the time of discharge are estimated to be a one-third to two-third reduction in primary drug consumption and other criminal activities and substantial improvements in rates of employment and education. Outcomes generally improve the longer the patient remains in the programme, but there has been very little research of the relative effectiveness of shorter and longer term programmes and there are very variable rates of treatment completion in the different programmes.

A recent randomised control trial by McCusker et al (1995) compared programmes that differed in planned duration of treatment. Retention rates over comparable time periods differed minimally by planned treatment duration and the longer programmes had lower completion rates. There was no effect in either trial of planned treatment duration or changes in outcome at two and six months.

0. IN-PATIENT TREATMENT SERVICES

These services generally provide detoxification and early rehabilitation with short stays from two weeks to twelve weeks maximum. They have significantly higher rates of completion of detoxification for opiate dependents than the out patient or community setting. All who are referred have failed in the community setting. A significant number of users in patient detoxification go on to residential rehabilitation facilities and overall there is a need to look at the articulation between the provision of in-patient facilities and residential treatment facilities and day care facilities. The average provision of these facilities appears to range between 0.5 and 1.5 per hundred thousand adult population.

COUNSELLING

Overall there is a need to take a realistic and integrated approach to the management of drug misuse problems because of the complex nature of this problem. The approach to working with housing and social problems, criminal justice problems, psychological and health problems does not readily fall into the category of traditional counselling and the approach requires an eclectic mix of skills along with a structured and coherent approach to problem solving. Despite the central role of this activity in drug treatment services there is a scarcity of literature evaluating these interventions. One well-conducted study in North America on the role of counselling in methadone maintenance demonstrated significant added benefit by the addition of counselling to this treatment and other studies by the same author have shown that the characteristics and skills of the counsellor can have a significant impact on the treatment outcome. Overall there is a need for more work to evaluate the benefits of vocational, educational and psychological approaches to these types of helping interventions. Operational standards should exist that ensure that individuals do not engage in-depth work beyond their competency and training.

The key structured counselling approaches are the cognitive behavioural approaches with an emphasis on motivational interviewing and relapse prevention but there has been limited controlled evaluation of these interventions.

GENERAL PRACTICE

There is a reasonable U.K. literature on the role of general practice in management of drug misusers. There have been few experimental studies but the more descriptive studies support the capacity of general practitioners to effectively manage drug misusers with the backup of specialist services. General practitioners are viewed as central to task of managing drug misusers because of their capacity for continuity of care, involvement with and knowledge of other family members, capacity for multiagency liaison, capacity to ensure that other areas of health care need are adequately addressed.