

Rialto Community Drug Team

Policy Discussion Paper

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Foreword

The publication of this report is timely. Coinciding as it does with the official launch of the Rialto Community Drug Team, the report gives expression to the team's commitment to a wider policy discussion of its aims and activities. Since it first commenced operating in 1992 the team has endeavoured to ensure that the unique community-health board partnership it was trying to develop would be subject to rigorous debate and analysis. In the first instance, debate was generated at a local, community level. Policy options and strategic issues were developed and teased out, not only at regular team meetings, but publicly and openly at community forums and through various other consultative mechanisms. Although the team was involved in bottoms-up development it was always conscious that the process it was testing and developing was a critical, if understated, component of official policy as enunciated in the *Government Strategy to Prevent Drug Misuse, 1991*. This policy advocated the setting up of community drug teams. As only two community drug teams were set up (and the other of these has ceased operating) the work of the Rialto team provides a unique basis for reviewing the potential and limitations of community models for tackling drug problems. In this report, Matt Bowden's appraisal of community drug teams, not only reviews the progress of the Rialto model, it also provides a wider context for understanding this progress, particularly in terms of developments in the UK and the persistence of a policy vacuum in relation to these issues in Dublin.

Given the local political and security controversies generated by Dublin's drug problems over the last sixteen years it seems quite incredible that the community dimension has been so lacking in policy development and that such a serious policy vacuum has been allowed to develop. The underbelly of poverty and deprivation that is so characteristic of drug problems was every bit as apparent at their outset as it is today. There is some evidence of an administrative and policy shift towards understanding and acknowledging this dimension and perhaps this is another reason why Matt Bowden's report is timely. The recently published *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* clearly prioritises areas and communities in Dublin (and North Cork) for targeting drug treatment resources. This report's proposal to set up local task forces to coordinate interventions is a further acknowledgement of the critical importance of the community dimension. It is to be hoped that Matt Bowden's report, together with other reflections on the setting up and operation of the Rialto Community Drug Team, can provide some insight into how the government's recommendation on local task forces can have practical and meaningful value.

Rialto Community Drug Team

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1. INTRODUCTION

1.1. BACKGROUND, CONTEXT AND TERMS OF REFERENCE

Rialto Community Drug Team (RCDT) has been in operation since September 1992. It is a partnership between the Rialto Youth Project (RYP) and the Eastern Health Board (EHB). In March 1996 both organisations had two representatives on the Board of Management. From April 1996 the management committee was broadened to include an additional community member nominated by the Rialto Network, and one more member from the EHB social work service. The RCDT was the outcome of discussions between the Youth Project and Dr Joe Barry of the Eastern Health Board which began in April 1992. The first Board of Management meeting took place in early 1993. Both 'constituent' organisations have contributed resources – the RYP as a component of the Rialto Development Association (RDA) has contributed physical space, its experience of working with young people and the goodwill which it has accumulated over the 15 years of its existence; the EHB has contributed staffing and a budget as well as its expertise and professional resources. The management board came together as a structure to support the work of the staff, to plan a programme, secure a premises and to engage in the development of policies to guide the work of the team. It has decided to work within the Community Drug Team model as proposed in the 1991 Government Strategy to Prevent Drug Misuse.

In pursuing this model, the RCDT has been seriously hampered by the lack of policy development at national and regional level since 1991. Despite this, the RCDT has strategically sought to develop an appropriate community response model. At this point in its development, all of the 'elements' of an ideal CDT model are not in place. The RCDT has nevertheless, made significant achievements which are outlined in section 4 of this paper. These achievements have largely been in the area of community development which have secured the RCDT in the locality and have created an awareness of the need to support drug users in the community.

In policy terms, little development has taken place in relation to CDTs in Ireland since the 1991 Government document. This review and discussion paper is an attempt to identify key issues and to generate a debate about the role and the development potential of CDTs in tackling problem drug use in Dublin in the late 1990s. This report articulates the main points of learning from the RCDT experience and to relate this to the policy context.

In specific terms, the RCDT has commissioned Matt Bowden, an independent researcher

- (i) to examine the RCDT, in terms of its development and activities, against the broader policy context and to draw out the key learning;
- (ii) to identify key issues in relation to the development of CDT's in the context of drug treatment and support policies;
- (iii) to make appropriate recommendations.

Methods used in preparing this paper included a series of semi-structured interviews conducted with members of the staff, the management board, local activists and policy makers. These interviews have been used to identify key issues and pose key development questions as summarised in sections four and five of this document. The review has also involved a detailed study of the appropriate internal documents of the RCDT, policy reports and relevant academic literature.

1.2. OVERVIEW

Community Drug Teams (CDTs) were introduced in the UK in the 1980s to cope with a growing level of opiate use. The introduction of CDTs was precipitated by a general shift in public health policy from specialised hospital based treatment towards locally based services with input from general medical practitioners (GPs). In the treatment of drug users, GPs were to be involved in treating users within their local communities with the back up and support of district based health services. The CDT would be a co-ordinating and advisory support to GPs and other professionals. This model failed to gain a foothold in that GPs did not take on problem drug users in sufficient numbers.

The growth of opiate use in Dublin from the late 1970s and through the 1980s placed unprecedented pressure on the small scale specialist treatment services. These had been introduced in the 1970s to deal largely with a small drug using subculture. Shifts in the levels of heroin use and the spatial concentration of that use precipitated a crisis for the public health authorities. Public policy makers have since then attempted to reorient services to incorporate the input of general practitioners within a model which utilises the inputs of central and district treatment services. In 1991, the Government Strategy to Prevent Drug Misuse gave a greater emphasis to 'decentralised' services which gave responsibility for drug services to the health boards who would deal with the crisis through promoting a role for

GPs, by establishing CDTs (in priority areas) and district level clinical services. The shift in emphasis reflected the demand for an urgent response to the spread of HIV and not as a result of any newly discovered social altruism on the part of Government. Paradoxically, the shift towards a decentralised model was paralleled by an increased role for the National Drug Treatment Centre at Trinity Court which has precipitated a general confusion given that the spatial concentration for opiate use is largely confined within the boundaries of one health board. Thus, in the Eastern Health Board area, there are, for all intents and purposes, two statutory models of provision.

In relation to the proposals around CDTs in priority areas, the 1991 Government Strategy document was greatly influenced by the debate generated in a discussion paper on Drug Treatment Policies, published by the Ana Liffey Project. Since 1991, only one CDT, in Rialto, remains operational. Another which was established in Ballymun ceased operating after less than three years. The RCDT has operated since late 1992 without the range supports envisaged in the 1991 document. Its services and operations have been constricted by the absence of the support of GP prescribing and a district treatment service. It has no primary health care service for drug users. It has however, worked diligently to develop a model of CDT which is moving towards the integration of a community development approach within its role as an agent of public health policy.

The RCDT has created the conditions for supporting problem drug users in their own neighbourhoods through its work which engages the local community in the formulation of CDT policy; it promotes a pro-service-user ethos amongst community groups, and creates awareness of the CDT as a constructive model for managing problem drug use. It has successfully engaged drug users and their families, made strategic alliances with support agencies and established relationships with some GPs despite the limits placed on it by a policy framework which is only slowly being implemented.

The RCDT has been a worthwhile partnership between the health board and the community. At this juncture, the RCDT needs to expand and develop its service in order to have a greater impact on problem drug use in its area. In this context it could benefit from the expansion of local GP involvement in both prescribing to stabilised drug users and the provision of primary health care, and from the input of other services to support drug users. It requires greater resources than those presently available if it is to rise to the challenge now presented to it.

2. COMMUNITY DRUG TEAMS – NON-SPECIALIST SERVICES IN DRUG TREATMENT: THE UK EXPERIENCE.

2.1. INTRODUCTION

Up to the 1960s drug misuse in Britain was largely a middle class phenomenon and both policy and practice reflected the fact that the addict (particularly the opiate addict) was either one of two main categories; a ‘professional addict’ – a physician or paramedic whose abuse of drugs was related to the fact that they had easy access to them; a ‘therapeutic addict’ as a person who became addicted subsequent to a course of treatment requiring an addictive drug such as morphine or cocaine. In this context, medical practitioners were lawfully entitled to prescribe opiates and cocaine in the treatment of addiction. In the 1960s drug misuse became bound up with a youth subculture or counter culture which threatened the status quo. Societal reaction to such movements were described by sociologists at the time as ‘moral panic’ with specialist professions and services as agents in its management.

The analysis guiding official policy at the time rested on the assumption that the increase in drug taking was the result of a few ‘renegade’ doctors who engaged in overprescribing. The recommendations of the Brain Committee Report (1964) were taken up by the Home Office and enshrined in the 1967 Dangerous Drugs Act after which opiate or cocaine could only be used in the treatment of addiction under special licence from the Home Office, and in the context of specialist drug treatment clinics. Medical treatment for drug addiction would until after the 1982 ACMD report, be treated by ‘specialist’ hospital based doctors (mainly consultant psychiatrists). In this context, the role of the generalist physician in treating the patient in the community gave way to the predominance of the specialist (Glanz, 1994, pp. 151-153).

2.2. THE ADVISORY COUNCIL ON THE MISUSE OF DRUGS (ACMD) REPORT ON TREATMENT AND REHABILITATION (1982).

The 1982 ACMD report saw it necessary to dispense with the stereotypical description of the deviant ‘addict’ and adopted the concept of ‘problem drug user’. In the late 1970s and early 1980s the increase in the supply of cheap street heroin gave rise to a substantially different category of drug user who was typically unemployed, an early school-leaver and from a socially disadvantaged background. The Treatment and Rehabilitation report proposed a ‘problem oriented approach which recognises that the drug misuser may experience a range

of problems and that drug misuse was but one factor' (ACMD, 1982, p. 47). Moreover it accepted that there was a wider social basis of drug use and that a broader range of generic services should be mobilised in response. The Treatment and Rehabilitation Report advocated that:

Problem drug taking should not be seen only as a form of physical or psychological disorder to be treated in isolation. It must be set in the context of society as a whole. The reasons why a person misuses drugs and develops problems from drug use are usually complex and often spring from the social conditions in which he lives. It is important, therefore, that as well as the more specialist services traditionally associated with drug misuse, the generic services which at present do not always consider that they have a role to play should become involved in the rehabilitation of problem drug takers (p 36).

This is the rationale upon which the ACMD based its recommendation that the appropriate strategy for dealing with problem drug use would involve an integrated model in which the 'specialist' regional services provided the necessary support structure for 'generic' services at local level. It proposed that the establishment of regional multi-disciplinary drug problem teams would provide an assessment service, advise colleagues on all aspects of treatment, liaise with appropriate agencies as well as providing a regionally co-ordinated clinical service (p. 39).

At the local level, the ACMD recommended the establishment of drug advisory committees made up of members of statutory and non-statutory bodies providing services for problem drug users. In addition it proposed the setting up of 'district drug problem teams'. Such teams would be inter-agency partnerships and they would be made up of specialist (and primary) health care professionals as well as other non-specialist personnel. Each agency would be required to provide an input such as medical sessions from the health authorities and include personnel such as a doctor, nurse and district health visitor, social workers, probation officers community workers and so on (pp. 135-138).

The 1982 ACMD report thus laid the foundation for an integrated model which departed from the 'specialist' model in which the drug user was a stereotyped and abnormal individual. The new model disposed of the disease concept and embraced a more broadly based normalisation approach which accepts a more relativist conception of drug use and as such endorsed the idea that contemporary society is socially and culturally heterogeneous.

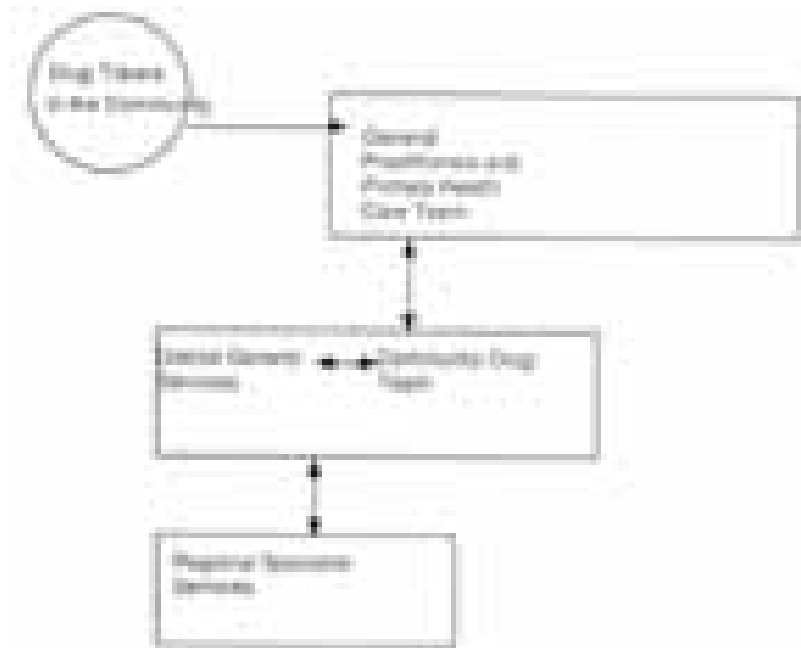
2.3. *THE ESTABLISHMENT OF COMMUNITY DRUG TEAMS (CDTS)*

The district drug problem teams were established across Britain in the 1980s but specifically pioneered in the North Western Region and then referred to as Community Drug Teams. These were based on the integrated model proposed by the ACMD (1982). A total of twenty CDTs were established in the North West by 1990. In addition to the CDT the regional service operated local satellite clinics with the specific goal of engaging, training and upskilling community based general practitioners and other generic primary health care workers. The assumption which informed this development was that straightforward methadone (and other) withdrawal programmes should be within the repertoire of general health workers, especially general practitioners, with the back-up of the psychiatric and social work services. The model would have different strata with the various specialist and generic personnel acting as ‘filters’ between the levels, as in Figure 1 below.

Strang and Clement (1994) describe the community drug team as a model in which the generic services at local level become the ‘client’. The CDT acts then as a specialist ‘consultancy’ within the community. They potentially act as catalysts to identify needs and plan appropriate strategies, a role which the ACMD envisaged for them (ACMD 1982, p. 136) and their strategic position within the community bolsters the ability of services to respond:

...all CDTs have a clear understanding of a people whom they serve and of a geographical plot which is their responsibility. From this standpoint they are well positioned to be able to consider possible areas of unmet need to which services might be more specifically targeted – either geographical areas in which there is poor service access or uptake, or groups within the population who appear not to be using the services for which they appear to have a need (Strang and Clement, 1994, p. 209).

Figure 1: The Integrated Model of Care for Problem Drug Users.



Source: Strang *et al* (1991).

In the North Western Region of the UK, drug teams operated at the health district level; in some instances covering whole towns or cities with comparatively large populations.

2.4. THE ROLE OF THE 'GENERALIST'

Central to the success of the integrated model was the role which general practitioners would play at community level in prescribing methadone for detoxification. Glanz (1994) suggests that the official recognition of the role of the GP was vital in the 1980s in that the spread of the problem outstripped the capacity of the clinic system. In addition, he notes the significant shift from a 'disease' concept, which underpinned the specialist model, to a 'normalisation' concept which the ACMD 1982 report helped to introduce (p. 157). The establishment of a set of 'Guidelines for Good Clinical Practice' by the British Department of Health in 1984 heralded the 'reinstatement' of the GP in drug treatment.

Since then, there has been a general resistance by GPs to become involved. Strang (1994) suggests that they failed to respond to the ‘clarion call’. The overall absence of GP prescribing eventually led to an ‘exploitation’ of those who were willing to become involved who in turn became the ‘local specialist’ (p. 215). Some CDTs reported that their work in mobilising the input of GPs (and other professionals) was the most difficult task in their work, as Burke and Sheppard (1990) have noted:

The major problem we encounter is the often negative attitudes towards users found in other professionals. Together with the general air of mystery that surrounds drug use this often leads to a tendency to dump drug using clients on drug teams when this is an inappropriate response to the presenting problem (p. 18).

2.5. *THE EVALUATION OF CDTs IN THE NORTH WEST REGION OF THE UK*

An evaluation of CDTs in the north west region of the UK (Strang, 1991) was, de facto, the first test of the validity and performance of the integrated model. It is assumed that if the model is effective then there would be an observable shift in the numbers of problem drug users utilising the services of general practitioners. The research team analysed the returns made by doctors to a ‘drug misuse database’ in the three sample study areas. Two interviews, one at the start of the study period and another at the end, were conducted with general practitioners to establish their level of skill and knowledge, their perception of their own role and that of the CDT, the numbers of drug users presenting and the response made by the GPs. The following findings are noteworthy:-

- GPs by and large perceive that it is their role to refer on drug users to the specialist services. GPs did not attend training sessions organised by the CDTs which demonstrates that there has been a low level of involvement (p. 35);
- There was an overall drop in the mean numbers of drug users presenting to GPs over the time of the study. GPs seemed to want to keep numbers small for fear that they would get a reputation and be ‘swamped’ by the client group (p. 36);
- There was an overall drop in the proportion of drug misusers taken on by GPs and there was a high level of cases where ‘nothing was done’. The general practitioners explained this by saying that the client requested drugs. The authors note. “While

such a request could be an attempt to obtain a steady supply of opiates, it could also be a legitimate request for reduction. The lack of clarity of this issue reflects the insecurity which exists among GPs over their role as prescribers of drugs for drug misusers. GPs did not want to be ‘taken for a ride’ ” (p 40);

As a result of the above, the authors argue for the strengthening of a joint approach between specialists and non-specialists in the provision of support, guidelines, and access to facilities which might serve to lessen the ‘apprehension’ of the GPs.

The research team analysed the returns to the database made by CDTs. The ratio of referral to ‘walk in’ was 60:40, implying a high level of either self, family or friend referral. The authors note:

The high proportion of self referrals to the CDT could be put forward as an argument to justify their operation as a direct access service. This policy does appear to enhance the attractiveness of the service to this group of clients and self referrals have become an increasingly significant fraction of CDT caseload, (p. 44).

The evaluation noted some general findings in relation to CDTs. On the whole there was a ‘drift from consultancy to casework’. There were four reasons for this:

- (i) Drug workers in CDT were mostly from clinical or casework background – this was their only experience;
- (ii) As more drug misusers presented, ‘drug workers saw their clients’ problems as the most important pan of their work – the area where they could best contribute;
- (iii) Contact with GPs and general psychiatrists was frustrating and the ‘catalytic’ role of the CDT was difficult to communicate to doctors;
- (iv) The lack of interest and low level of involvement of GPs implied that CDT workers took up client work (p. 49).

The conflict between the role of casework and consultancy may have contributed to diminishing the overall impact of the service. The evaluation states:

The knock-on effect of such conflict was initially a further withdrawal of input into the difficult consultative role and, in some cases, a withdrawal from client oriented

work. There is, consequently, a real danger that the overall number of clients seen by the total service is diminished (p. 49).

The overall implication of the findings is that the integrated model put forward by the ACMD 1982 Report on Treatment and Rehabilitation has failed (p. 50). General Practitioners did not get involved in treating drug users and rather than creating an interactive model involving the integration of the regional specialists local generalists, the CDT has contributed to the 'reproduction of the specialist':

The most successful CDTs have developed links with one or more local doctors who provide detoxification and medical advice. The districts containing these teams have therefore developed a district drug specialist group (and)... in effect, recreated the specialist at local level (p. 50).

Moreover, the value of the CDT might be limited to attracting the clientele which no other service can:

The ratio of 'referrals over 'walk in' in the CDT caseload changed from approximately 60/40 at the start of the study period to 40/60 at the end of the study period; and this change to 40/60 continued for the year after the study period. Thus, there is evidence of a decreased involvement of the generalist and emergence of local (i.e. CDT) specialists who work with a sub-group of compliant local doctors. This may be the best that this model can achieve (p. 52).

On a positive note the study points out that drug teams with designated medical input have an appeal to the drug using population and that urgent consideration needs to be given to the place of such 'in-house' medical input. In relation to the overall strategy the study, rather pessimistically concludes that it is 'serious and worrying' that a policy which was premised on the expansion and introduction of non-specialist and non-doctor components of care, has through one of its main strategic elements (CDTs) recreated the provision of a specialist service:

With the advent of HIV and with the anticipated re-emergence of prescribing as a major component of care, the profoundly disappointing lack of significant response from the generalist doctors must call into question the viability of promoting a model of drug services based on a specialist/advisory consultancy service as recommended by the ACMD in 1982 (and as adopted nationally and locally since that date). The

questioning is all the more urgent in view of the ACMD's reliance on this model in their description of the modifications and expansions of services necessary in our preparation for, and response to, the HIV epidemic (p. 51).

2.6. *CONCLUSION*

The integrated model as proposed by the ACMD in 1982 has been problematic in its implementation. A key issue from the experience is that a model cannot be integrated unless the component parts are active in implementing it. The absence of such an equilibrium, “reproduced the specialist” at local level which was contrary to the goal of integration. Such a model then is not transportable to other contexts – the CDT as one element rests on all the others being in step, which was clearly not the case in the UK. Thus, CDTs in the Irish context are not likely to be successful in achieving their potential unless the other components of drug policy work to establish an equilibrium.

3. IRISH PUBLIC POLICY

3.1. POLICY DEVELOPMENTS

Current policy in relation to drug treatment and rehabilitation derives from the 1991 Government Strategy to Prevent Drug Misuse (see 3.2. below). This report reflected the predominance of an administrative ‘common sense’ approach in which no attempt was made to establish a conceptual distinction between the drug control policies and health and welfare policies which operate on radically different value systems (Butler, 1991, p. 224).

Reports of significant levels of opiate use amongst young people in small working class Dublin neighbourhoods, began to emerge in the late 1970s. These reports were widely publicised in the media. The Eastern Health Board (EHB) had been made aware of the problem through its own social work personnel. In 1982 the EHB established a ‘task force’ in response, yet despite the knowledge which the Board had from its own officers and community groups at the grassroots level, no new strategy developed.

After much media coverage and the leaking of a Medico-Social Research Board report, the Government established a Special Governmental Task Force in 1983. The report of the Task Force was not published but it did eventually leak. In a review of Irish drug policies. Butler (p. 220) reveals that the government report acknowledged that drug problems in Dublin were largely explicable in terms of poverty and powerlessness in certain neighbourhoods which they called ‘community priority areas’.

For at least two years prior to the establishment of this Task Force, there had been a growing community response in the Ballymun, North Inner City and St Teresa’s Gardens areas. The community groups attempted to work in co-operation with the statutory agencies but these relationships were fraught with tensions and conflicts:

Not only were the community groups making financial demands at a time when resources for this purpose were quite restricted; philosophically they posed a threat to the status quo through their insistence that drug users should be seen, understood and helped in the context of their families and neighbourhoods, rather than seen as having a clinical condition which warranted treatment at a centralised facility at a considerable remove from their usual environment (p. 223).

The 1980s was marked, in terms of drug misuse policy, by an inability of the Government, the Eastern Health Board and the treatment agencies to understand the complexity of the problem and the conditions in the communities which contributed to it. The EHB in particular, failed to forge sound relations with community groups which were closer to the problem in terms of their insight, their relationships with users and their political legitimacy within the communities. Butler notes that in 1985 the EHB appointed a counsellor in Ballymun which created conflict. The Youth Action Project (YAP) had a worker already in place and the EHB failed to understand how its action might have undermined the position of the YAP (p. 223).

Following the Special Governmental Task Force, a National Co-ordinating Committee on Drug Abuse was established which made one annual report. The make up of the Committee was restricted to the 'usual experts' drawn from treatment agencies committed to the total abstinence approach, the Gardai and Customs services. The Committee was abandoned and later reconstituted in 1989.

A noted shift in policy development occurred in the late 1980s with the urgency surrounding the need to establish services for intravenous drug users to prevent the spread of the human immuno-deficiency virus (HIV). In 1989 the EHB opened the AIDS Resource Centre in Baggott Street which initially, for the first year, provided outreach counselling services, especially for persons who were unwilling to avail of existing specialist drugs services which operated strict abstinence-only approaches. Eventually, a wider range of programmes were developed on the Baggott Street complex including needle exchange and methadone maintenance. These developments reflected a growing momentum towards decentralised services. The move to such a decentralised service would require a reappraisal of the American style 'war on drugs' sensibility which dominated drug policy making. The so called 'intersectoral collaboration' espoused by the Department of Health in the 1980s was built on a consensus which saw the creation of a snug relationship between a 'total abstinence' orthodoxy and the forces of law and order, whose ability to comprehend the drug situation was blinded by their stereotypical view of an essentially vulnerable and non-conforming sub-group in the population. Butler (1991) suggests in concluding his policy review

...that the consensus which has been a feature of Irish drug policy making has been superficial, that it has been achieved and maintained by ignoring many real policy dilemmas, and that such consensus-seeking may in the long run be of less societal

value than an open acknowledgement of institutional conflict and cultural ambivalence (p. 230).

3.2. *THE GOVERNMENT STRATEGY TO PREVENT DRUG MISUSE 1991*

The *Government Strategy to Prevent Drug Misuse* (Department of Health, 1991) took a ‘middle ground’ approach to these emerging conflicts. It expanded the role of regional and local services including giving responsibility to the Health Boards for drug treatment in its area while at the same time expanded the role of the centralised specialist Drug Treatment Centre at Trinity Court. This has led to a dual model which appears to many informed commentators as wasteful and duplicating. Moreover, the ‘middle-ground’ approach perhaps reflects a degree of political ambivalence. It tries to be ‘all things to all people’ rather than taking a particular policy line and sticking to it.

In adopting the middle-of-the-road position the document outlines the rationale for a policy framework as follows:

Of its nature, the treatment, care and management of the drug misuser does not lend itself to any “one solution approach”. The Government accept that the provision of services aimed at the achievement of a drug-free society only or harm reduction programmes solely are inappropriate. There is a need to make available to the drug misuser, a range of possible approaches and the means of access to the services most appropriate to his/her immediate needs and capabilities. A fundamental consideration in this respect is to ensure that services available are attractive and accessible in order to encourage misusers to avail of them and to motivate them to continue with treatment (p. 16).

The report was divided in two major sections – one dealing with supply reduction and the other with demand reduction. In the context of drug misuse and AIDS a range of responses were proposed:-

- outreach, methadone maintenance and needle exchange;
- the appointment of regional co-ordinators in Health Boards;
- Health Boards will be responsible for the co-ordination of programmes in the AIDS/drugs area;
- provision, co-ordination and funding of treatment should be the responsibility of the Health Boards;

- Trinity Court would provide a national specialist treatment and detoxification service on behalf of the Health Boards.

The establishment of a dual treatment service model involving both Trinity Court and the Health Board is evident here. There is considerable lack of discussion of the links between the two. Moreover, the role of the Treatment Centre at Trinity Court being a ‘national service’ seems to reduce its importance given the spatial concentration of the problem at the time and as it is now in the greater Dublin area.

A subsection was devoted to setting the framework for the establishment of CDTs. There was no discussion of the rationale for introducing these other than a passing acknowledgement of the fact that drug misusers live in neighbourhoods and with families. The ACMD report was not mentioned and no comparative analysis with the UK policy was drawn upon. However, the report went on to acknowledge that

...the Government believe that there is an overwhelming case to be made for decentralising services as far as is practicable to ensure accessibility and continuity of treatment (p. 18).

A key feature of CDTs is that they would have the services of professionals as each target area required such as those of a GP, outreach workers, public health nurse, social worker, treatment agency representatives, Garda Juvenile Liaison Officer or probation officer. The CDT did not have any treatment or medical function in its terms of reference. Its role would be

- identifying the extent of the drug misuse problem in its area of operation;
- identifying and establishing contact with known drug misusers and persons at risk;
- establishing links with the appropriate statutory and voluntary treatment services;
- referring individual drug misusers for assessment and treatment as appropriate; ongoing monitoring of individual drug misusers on referral back following initial assessment and treatment;
- assisting the local education services in developing appropriate and relevant primary prevention programmes;
- liaising with the prison services in the case of drug misusing prisoners from their area being released (pp. 18-19).

In addition to establishing this loose framework for CDTs, the document recognised the role of the primary health care doctor. The role which GPs play would be the same as in current practice where the local general practitioner would refer the patient for specialist assessment and treatment:

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 that there are fundamental differences it is felt that this model should be followed, as far as possible, in the case of drug misusers. This would involve the drug misusers either entering the Drug Treatment Centre “off the street” or being referred by the CDT for specialist assessment and treatment and then being referred back to the GP as part of the CDT, for ongoing care (p. 19).

The role of general practitioners in prescribing methadone is not spelled out in any detail in the document. Indeed, while the report claims to be an ‘integrated model’ the basis of this can only be found by reading between the lines. Put another way, the integrated model is implicit rather than explicit. The overall conclusion which may be drawn is that while creating the skeletal components of a more decentralised service, the lack of discussion of policy options, the lack of clarity vis a vis the role of the national and regional services and the implicit ‘roundabout’ way the model is presented, the 1991 Government Strategy to Prevent Drug Misuse failed to develop a coherent integrated approach. The reasons for this may be explained in part by the absence of an integrated strategy within the health services in general which has in large part been reactive rather than proactive. Such a strategy was not proposed until 1994, introduced by the then Minister for Health, Brendan Howlin TD., on the assumption that health services were hitherto not strategically planned or focused.

3.3. *HEALTH AND HEALTH PROMOTION STRATEGIES*

The document *Shaping a Healthier Future – A Strategy for effective health care in the 1990s* (Department of Health, 1994) provides an update on government thinking on the strategic development of health services. In appraising the health system the document recognises its key strengths and weaknesses and acknowledges that many services are not sufficiently focused or strategically planned, that community based services are not as developed as

would be appropriate to support institutional care, and that the organisational and management structures are outdated. The latter would need to be changed to provide effective decision making as well as greater accountability (p. 10).

Three key principles underpin the strategy – *equity* in which special attention will be given to certain disadvantaged groups, *quality of service* to be evaluated by a clinical audit and accountability to make the system customer conscious.

The strategy proposed that those in contact with the service would receive an outcome which could be measured in terms of its health and social gain. Health gain is concerned with improving health status of clients of the service. Social gain is the addition to the quality of life of clients and carers (p. 16). Traditionally, output in the health sector has been measured in bed units filled. Thus, the document takes a broader concept of health outcomes in terms of value added. However, it does not express social gain as a communal or societal outcome. The strategy does stress the need for targeting of geographic areas and groups but also that the causal factors contributing to low health status, poverty and unemployment are outside the direct control of the health service. The document restates the need for the evaluation of the relationship between acute hospital care and community services. Planning and decision making would then be focused on service delivery which maximises social and health gain while ensuring that treatment or care is provided in its most appropriate setting (p. 24).

In proposing structures the strategy recognises the inadequacy of decision making and accountability, the confusion of executive and political functions, and insufficient integration of services. This is particularly true of the Eastern Health Board which, it was proposed, would be replaced by a new health authority with responsibility for health and personal social services in the Eastern region (p. 24). The document also suggests that the ‘Department of Health will no longer be involved in the detailed management of the health services’ (p. 25) and that this function would be the responsibility of the new regional authorities.

The strategy recognises the role of the voluntary sector which ranges from large hospitals providing acute and rehabilitative services to small community groups involved in local initiatives. Moreover;

Their independence enables them to harness community support and to complement the statutory services in an innovative and flexible manner. In future the voluntary agencies will receive funding from the health authorities, to whom they will be accountable for the public funds which they have received. For the first time a

specific statutory framework will be created between the health authorities and the voluntary agencies which recognises the role and responsibilities of both parties. The independent identity of the voluntary agencies will be fully respected under the new structure. They will continue to have a direct input to the overall development of policy at national level (p. 33).

In addition, the greatest potential of the Health Strategy vis a vis marginalised communities, is the policy of targeting resources towards areas or groups with low health status and giving them priority. Moreover, the requirement that the health boards identify “health development sectors” in their areas, presents an opportunity for intersectoral collaboration and community development.

The document envisages a ‘participative’ service primarily by stressing that it is made up of a plurality of ‘participants’. The mode in which this is communicated is in terms of developing a ‘consumer orientation’ in the service. It proposes the establishment of advisory groups in each health region to input the views of users, a complaints procedure and giving new health authorities the statutory function of channelling the views of users to the Minister (p 40).

The health strategy is to be implemented over a long-term period but it sets targets and goals in a four-year action plan from 1994 to 1997. In relation to addressing drug misuse the strategy states that the Department of Health will provide for the development of appropriate preventative, treatment and rehabilitation services involving:

- Primary prevention in schools and targeted at key groups;
- Increase in detoxification and rehabilitative facilities;
- Enhanced support for voluntary groups and local services;
- Provision of four primary care clinics in Dublin which would provide harm reduction and assessment services;
- The involvement of general practitioners in the implementation of the methadone protocol (see section 3.6).

In general, the Health Strategy is aspirational. It adopts a market discourse in assuming that the service needs to become ‘customer orientated’ and proposes methods of achieving this. While committing itself to the principle of equity, there is a danger that the target groups it wishes to focus upon will be marginalised in the context of the customer/service-provider relationship. The marginal position of the drug misuse targets in the document and the

relative vagueness of their meaning does not inspire confidence in the strategy to embrace marginal groups who are devoid of purchasing power or equity within the market context.

While acknowledging the role of the voluntary sector and the need for a statutory framework, the document falls short on any discussion of the involvement of community groups working with marginal or vulnerable groups. There is no attempt to explore models which embrace a community development perspective or of 'partnership' or consensual management models involving statutory and community groups. Such models are an integral part of the Irish Government's 'Operational Programme for Local Urban and Rural Development'. Area Partnership Companies (APCs) which are made up of members of statutory, community and social partner sectors, include the contribution of community and voluntary organisations to an agreed 'area action plan'. Thus, the community is part of the planning and implementation process. There are lessons from this approach for policy and practice in health, and particularly, drug misuse policy, yet the Health Strategy did not explore the issue.

The government's *Health Promotion Strategy* (Department of Health, 1995) is intended to complement the Health Strategy by recognising that individuals wishing to adopt a healthy lifestyle can be prevented by socio-economic or environmental factors beyond their control. Healthy lifestyles are determined by social, economic, cultural, physical and ethical factors, plus information and skills. In November 1986 Ireland endorsed the Ottawa Charter, an international convention on health promotion. The key elements of this include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting health services (pp. 2-3). In the context of the Ottawa Charter, the strengthening of community action would essentially involve the establishment of a model which integrates 'top down' policy development with a 'bottom up' input.

Like the general Health Strategy, the document stresses the need for targeting:

In the interest of achieving equity in health status, it makes sense to give priority to those who are often at a disadvantage e.g. those in lower socio-economic groups....The assumptions underlying the rationale for health promotion imply that reducing the risk factors for preventable illnesses will make an important contribution to enhancing health status (p. 18).

Health promotion strategy would rely on the development of partnerships with key organisations. The document details the need for a ‘multisectoral’ approach in discrete settings reflecting a need to normalise health promotion in everyday social interaction;

Multi-sectoral co-operation, either within individual settings, or across a number of them, adds significantly to the opportunities for progress towards the national goals and targets. Opportunities to work towards the achievement of the goals and targets and indeed of other health and social gains, will be similarly enhanced if action, above all joint action, is pursued in various discrete “settings” in the places where people live and work (p. 19).

In pursuing a multi-sectoral approach a number of key measures need to be put in place including:

- a National Consultative committee;
- regional consultative bodies;
- the establishment of departments of public medicine in Health Boards to identify ‘blackspots’ and at-risk groups;
- the establishment of national and regional General Practice Units (GPs) which, in recognising that general practitioners have a key role in the context of the provision of primary health care, will take action to enhance the quality and effectiveness of service;
- the development of the potential of the voluntary sector;
- broadening the range of skills available as technical support.

In the context of the latter two points above, it is significant that the document recognises the need for a broad range of skills such as community development and adult education in the Health Promotion Unit. The most important outcome arising from the Health Promotion Strategy for the purposes of this discussion is that it recognises the need to target areas and groups, and to adopt multi-sectoral approaches to delivery.

However, it is worrying that drug users as a group are not significantly targeted in either document. While the specific reference to targeting as it relates to ‘lower socio-economic groups’ and ‘disadvantaged’ is a welcome and hopeful feature of both documents, problem drug use in disadvantaged working class neighbourhoods in the Dublin area is marginal

within current health strategy. The key challenge to the health service response is the role which it can play in creating linkages and partnerships within the community.

Thus, in optimising the multi-sectoral approach, the evolving health policy framework must demonstrate a willingness to learn from other sectors, not least the community sector and especially those directly engaged in tackling problem drug use at community level. The success of such integrated multi-sectoral models may only be assessable after a number of years. However, a cursory view of current policies in the Eastern Health Board area might elucidate the possibilities of the Health Strategy.

3.4. CURRENT DRUG POLICY AND DRUG SERVICES IN THE EASTERN HEALTH BOARD

In April 1996, the Eastern Health Board held a special meeting to review the developments of the drug service in 1995 and to consider the plan for 1996. In addition, an external review was conducted by Dr Michael Farrell of the National Addiction Centre and Institute of Psychiatry, University of London, and Mr Ernst Buning, Psychologist, Bureau of International Affairs, Amsterdam. This section deals with the report prepared by the Board, and section 3.5. below summarises the external review.

Developments in the drug service in 1995, the report outlines, include:

- 10 bed detoxification unit at Cherry Orchard Hospital;
- two additional community drug centres partially opened at Ballymun and Blanchardstown;
- two additional community drug teams established in Tallaght and Coolock;
- increased capacity of rehabilitative services;
- the establishment of an Eastern Region Co-ordinating Committee;
- a new Strategy Group established.

The Board plans to increase the access to and capacity of methadone treatment services in 1996, more GP prescribing, the establishment of a full range of services in the South Inner City area and so on (EHB, 1996, p. 3). The Board proposes to 'strengthen the management structures in a number of ways'. Most significantly a fourth Programme Manager will be appointed who will have responsibility for drug and alcohol services, adult homelessness and disadvantaged as well as managing the Board's contribution to community developments

through the Area Partnership Companies (APCs) and other cross-sectoral initiatives including those focusing on drug misuse. Interestingly, the report goes on, ‘the development of a number of health development sector initiatives relating to drug users and others in line with the health strategy would be included in this responsibility’ (p. 4).

The Board has established a strategy and development group which includes the new Director of Drug Services. The report suggests that a number of ‘community initiatives’ will be supported by the board, although it does not elaborate on the nature or content of these. Nevertheless, it would be fair to say that there seems to be the willingness to broaden the scope of the service and to enhance links with other sectors. The appointment of a new Programme Manager, the establishment of the strategy group and the expressed willingness on the part of the EHB to identify and build ‘health development sectors’ creates an opportunity to develop innovative community based responses.

The report gives no indication of how the community will have an impact into service management and policy development which could well indicate an uncertainty within the EHB management about the multi-sectoral approach or indeed a certainty about how far it is prepared to go to embrace inclusive management strategies and policy making mechanisms.

3.5. *THE EXTERNAL REVIEW OF EASTERN HEALTH BOARD SERVICES*

It is worth noting a number of the issues raised by the Farrell and Buning (1996) report. The terms of reference for the review covers the evolution of current policies, service from non-government organisations and practitioners with reference to the co-ordination with EHB services, and a comparison of responses in the EHB area in the context of trends abroad. The review also took account of mechanisms for ‘consultation with and gaining support of local community interests’ (p. 5).

In tracing the development of services the authors cite the problem of HIV and AIDS among the intravenous drug using population as the key factor promoting a service response. The drug service is under the management of the public health service and run in conjunction with other HIV related services (p. 8):

This service started as a low threshold low dose harm reduction and methadone dispensing service but subsequently established a methadone maintenance service in Baggott 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 (P. 8).

The authors note the role of a strong voluntary sector including the growth of a street agency response in the 1980s which has had a major impact on policy development. They suggest that such organisations have an important role to play in that they provide direct and alternative access services, have flexibility and innovatory potential. The authors are rather Darwinist when they suggest the need 'to foster and secure the stronger organisations' (p. 9).

The report goes on to identify a need for 'community epidemiological studies' as a means of profiling the target population and suggests a number of possible methods of conducting this, such as a capture-recapture study. In addition the authors stress the need for ongoing monitoring and evaluation particularly to establish the performance of service in having a physical, psychological and social gain (p. 10).

The authors acknowledge that the waiting list for methadone treatment gives rise to concerns from individuals and organisations as drug users awaiting treatment are involved in HIV risk taking behaviour, crime and they cause disorder. They make 'inappropriate demands on primary care services and alienate GPs'. The community perceives this, the authors claim, as a failure of service and as a sign of inadequate response to the drug problem which spurns ad hoc and uncoordinated responses (p. 12). The report comments on the need to implement the methadone protocol and to create a feedback mechanism to the EHBs strategy group and the regional co-ordinating committee (p. 13). The report goes on to make a number of observations and recommendations in the context of specific services.

For the purposes of this discussion, the key section of the Farrell and Buning report is section 7.1. on community consultation. In planning to expand services the EHB will initiate services for drug users in their local communities through community drug centres, local GPs, community pharmacists, and a mobile bus service. It has appointed an officer, who is a member of the strategy group with a specific community liaison brief. At this point in the report the authors come to a conclusion which is contentious. When the report says 'community resistance to the establishment of services for drug services is an international phenomenon and is directly linked to the marginal social status of service users' (p. 17), it treats the issue in a rather unproblematic way. It assumes that the community is

homogeneous and that the form of resistance is uniformly related to the social status of the client group. There are other forms of resistance – such as community groups who demand a say in the planning and implementation of services (see section 4). It exacerbates the misunderstanding when the authors suggest:

The need for locally based services is a key aspect of the EHB 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 (p. 18).

While the desire to protect the needy is a worthy and defensible notion, it is decidedly arrogant to suggest that service provision does not incorporate local community concerns. What is even more alarming, following the earlier point about assuming the community is homogenous, is that such statements unfortunately conflate conservative or protective community tendencies with progressive pro-client movements and may provide policy makers with an excuse to do nothing. The ‘no community veto’ might well be a euphemism for ‘no input into service management’, no alliance or partnerships. What the reviewers suggest eventually is that there should be ‘liaison’ with the community which is fed back to the Strategy Group. This may not go far enough to involve and incorporate community groups into service management and delivery.

If the view of the reviewers is endorsed by EHB policy then an historic opportunity to create participative mechanisms for a community input into planning, management and policy will be lost.

For some reason, while there was a short time frame involved, the evaluators did not visit the Rialto Community Drug Team. This may be the reason why they did not get a more dynamic insight into the micro political issues in the community vis a vis clinical drug services. It may also be the reason that their report is completely devoid of any analysis of CDTs at all. In fact, there is no reference to the phrase ‘community drug team’ and perhaps it confuses these with what are (perhaps mistakenly) called ‘community drug centres’.

Finally, the report does not deal with the link between the EHB services and those of the Drug Treatment Centre at Trinity Court. In this sense, the consultants report did not explore the full context and thus it did not help to address the contentious issue: why do we have, in the Dublin area, what is essentially, a dual system of service provision?

3.6. THE ROLE OF GPs AND THE POLICY CONTEXT FOR TREATMENT

All of the major policy documents produced by both Government and Health Boards have since 1991 emphasised an increased role for GP prescribing in the management of problem drug use. However, the support structures for implementing this policy have yet to be put in place. The Department of Health set up an expert group to report on the establishment of a Protocol for the Prescribing of Methadone (Department of Health, 1993a). The Department circulated general practitioners in September 1994 informing them of the new Protocol and seeking their co-operation in implementing the Expert Group's recommendations. Since then, the Government has been anxious that general practitioners would participate in the new protocol while doctors organisations claim that the fear of GPs is that the scheme would not have sufficient back-up resources. At this stage the progress in implementing the Protocol has been slow.

In setting out the issues in relation to methadone prescribing the review group agreed on basic tenets;

- maintenance programmes are for many users the most feasible option for stabilising their addiction;
- methadone prescribing is important to ensure the maximum number of users avail of treatment services and the prevention of HIV transmission through infected needles;
- methadone is the most appropriate drug in maintenance programmes.

The group endorsed the view of the Irish College of General Practitioners in supporting 'the provision of community drug teams and that these teams should work closely with local general practitioners. Doctors who wish to prescribe for patients with addiction problems should do so only when satisfied about the adequacy of support from the statutory and voluntary services and the availability of proper resources' (p. 5).

In section 3.2 of their report the group outlines the process of referral and support. It recommends that a person in difficulty should be referred to specialist services for assessment:

The initial referral could be from the individual's own doctor, public health nurse, drugs outreach worker, voluntary agency or by self-referral. Following assessment it is recommended that the individual should be offered a range of options including detoxification, support for a drug-free life, referral to a programme of rehabilitation, or a methadone maintenance programme. A key drug worker would be identified to work with this person on an ongoing basis. After stabilisation as drug-free or on a maintenance programme the individual would be introduced to a local doctor who had agreed to continue medical care and/or methadone maintenance at a level agreed between the doctor, the patient and the addiction services. The Group endorses the role of the community drug team and recommends the urgent establishment of other community drug teams in areas of greatest need (p. 5).

The report stresses the need for a 'keyworker' system as a means of communicating and dealing with gaps and issues in treatment, and that general practitioners work closely with their community pharmacist colleagues and addiction services. Implicit in section 3.6 of the report is that doctors should not engage in prescribing without being integrated within such a system.

The key proposal of the Group for controlling the decentralised prescription of methadone is the introduction of a 'treatment card' which would be issued following stabilisation by the Drug Treatment Centre or the health board addiction services. The Group favoured this to using such terminology as user 'registration' system, but in proposing that there be a centralised 'treatment list' it would be in essence a registration of some sort.

The Group proposed the establishment of a Liaison Group to ensure the protection of users/providers and to avoid double prescribing, and placed particular emphasis on confidentiality and the need for a high level of co-ordination. In addition, doctors would not be licensed but would register as a participant in the scheme. The Group also proposed that there should be initial monitoring of the co-operation between the voluntary and statutory bodies, between doctors and the central services, and the implementation of the prescription card scheme (pp. 10-12).

In commenting on the Group's recommendations it must be acknowledged that it is perhaps the clearest statement of how the system reaches a form of integration which other policy documents, including the 1991 Strategy document, have failed to do. Moreover, there is a

commendable attempt to acknowledge the role played by CDTs and the report includes their input as a vital mechanism for local co-ordination.

3.7. CONCLUSION

This section of the paper has traced the development of Irish drug policy. There have been many developments in drug and general health policies which underpin the position of an integrated locally based model. Policy makers have been slow to digest the concept of multi-sectoralism and community collaboration. No clear programme yet exists for implementing the ethos of the Health Strategy and the Health Promotion Strategy in the context of drug services. The CDT model does present real opportunities not only for inter-sectoral and interdisciplinary collaboration, but also to achieve health and social gains, and to promote community action.

Drug services policy has been hampered by the reluctance of GPs to become involved in treatment yet this position is understandable in the context of the lack of clear supports and controls. The methadone protocol which has been agreed is a major step forward in this regard. The pace of implementing the protocol has been exceedingly slow; while produced in March 1993 it has yet to be put into full operation. However, a pilot for the scheme is underway and its results are eagerly awaited.

4. RIALTO COMMUNITY DRUG TEAM

4.1. GENESIS AND EARLY DEVELOPMENT

The RCDT has its roots in the Rialto Youth Project (RYP). While drug use amongst young people has been a persistent phenomenon since the early 1980s, the numbers of young drug users using the services of the RYP become more stark in the early 1990s. The policy of the RYP had always been to refer to specialist treatment services or to the EHB addiction counselling service. Despite this policy, there was a general dissatisfaction with the fact that many of those referred to the services eventually found their way back to the RYP with no significant change in their situation.

Having given the matter some serious reflection at an evaluation session in 1991, the management and staff of the RYP drew up an initial strategy. It was clear to the RYP that there was a need to localise the response and a number of measures were taken in this context. Firstly, discussions with the EHB counselling service resulted in the operation of the service in the Rialto area for a specific number of hours per week. Secondly, the RYP in conjunction with the addiction counsellor presented a number of case studies to the specialist agencies at a special seminar. Thirdly, the profile of the problem needed to be addressed at local level and in this context the RYP hosted a remembrance service for those who had died as a result of drug use or AIDS related illnesses, called “Friends Remembering Friends”, and produced two plays on this theme.

Two important events occurred in 1991 – the launch of the Government Strategy to Prevent Drug Misuse, and the appointment of an AIDS/Drugs Co-ordinator by the Eastern Health Board. Arising from the publication of the policy document, the CDT model presented an opportunity for the RYP to develop the kind of local response it felt was necessary to tackle the problem. While the model did not reflect the precise vision of the RYP it was the closest approximation to it at the time.

Also in 1992, the RYP set up a drugs sub-group which had representatives from the local addiction counselling service and the AIDS/Drugs outreach programme. In September 1992, the RYP began detailed discussions and correspondence with the Drugs/AIDS Co-ordinator. Despite initial confusion over the type of response, there was a degree of support for the

ideas presented by the RYP. A strong case was made by the RYP for a model alternative to a clinical one, which while providing support services for drug users and their families, would also adopt a community development strategy as a means of creating awareness and gaining support for both the project and the client group.

An addiction counsellor was appointed to work in the Rialto area and would eventually become part of the RCDT. The appointment of Tony MacCarthaigh was welcomed by the RYP and the community as he had a familiarity with the project and the area, and was well respected even by groups against or hostile to working with drug users.

The EHB agreed with the RYP to establish the RCDT as a partnership venture between the two organisations. Thus, the initial management structure would be comprised of equal numbers. Each were to appoint two members. A consultation process followed within the RYP and its broad network. Members of the RYP management committee, volunteers and others with knowledge of the issue were invited to participate. It was considered vital that there would be a consultative process around the decision to appoint the two representatives and that there should be a thorough discussion in relation to the issues involved. Barry Cullen and Jim Lawlor were selected. The EHB appointed Dr Mary Scully and Gerry McAleenan.

Four key tasks faced the management committee in the first six months:-

- to clarify and define its own structure – management/staffing;
- to develop a strategy for gaining community support and a profile for the RCDT;
- to develop a mission statement;
- to design a programme based on a profile and assessment of needs.

One of the first issues the management committee discussed was whether it would become a legal entity in its own right. It decided not to do this but to remain legally attached to the RYP through its parent entity, the Rialto Development Association Limited. Thus, the EHB contracted with the RDA through the youth project.

An early strategy adopted by the management committee was the holding of a regular consultative forum to engage the community in the process. In addition, the local members of the management committee and the addiction counsellor expended much energy in countering negative rumours and misconceptions about the RCDT. A deliberate and decisive effort was made to engage with community leaders or potential ‘objectors’ as a pre-emptive strategy to clarify the role and potential of the RCDT in the community. It was considered

particularly important to demystify the methadone or prescribing issue. As a result of this the team gained credibility and legitimacy from a very early stage. The community forum also served as a means of informing and developing RCDT policy.

The management committee agreed on a mission statement and development goals in November 1993. The document sets out three responses to needs and issues in the Rialto area;

1. **A local drug service** for users and their families and the general community. The services to be developed with the participation of and in consultation with the people of the area, and in conjunction with specialised medical and other drug related services. The drug service, it was envisaged would have three interdependent components:-
 - drop-in, advice, information, referral and crisis counselling;
 - the operation of community-based treatment (including drug free and methadone- based approaches), counselling, and support programmes;
 - the provision of personal development, assertiveness and social skills programmes to promote reintegration of drug users.
2. RCDT, drawing on its own community-based model, seeks to promote the effective integration of social work, personal support and other welfare services. It seeks to develop links with Community Response to promote drug education and prevention programmes.
3. RCDT seeks to engage in research for the purposes of identifying needs and issues and as a means of contributing to official policy making.

In engaging in its day to day work the team developed a non-intrusive style which required listening and communicating with people in the community. The staff created respect, had no hidden agenda and were open. They were accountable. They built key alliances. Their commitment to the client group, the community and the management team showed in the rigour of their work. The role of the staff was to enter dialogue and meet needs.

Key to the success of the early development of the RCDT was the recruitment of a 'community drug worker'. The application to the EHB for the worker followed an initial meeting with the services Co-ordinator in September 1992. The role envisaged for the worker

was that he/she would develop a local response through the RCDT to the 'crisis' in the community, maintain a profile of the drug problem, support families and involve them in the response, establish bereavement programmes for children, support groups, educational programmes. The worker would be an integral part of the team. The community drugs worker was appointed in the summer of 1993.

4.2. ACTIVITIES, RESOURCES, NEEDS AND GAPS

Within one year of the appointment of the addiction counsellor, six months following the community drug worker, the RCDT had developed a comprehensive programme of activities. In the context of establishing a local service for drug users the team was engaged in:

- outreach work which aimed to make contact with users especially younger people, using informal and non-threatening approaches;
- prison work which aimed to provide a link for users in prison and on release, and to enhance support for users in prison;
- group work with two groups aimed at developing personal skills and exploring deeper personal issues related to drug use, respectively;
- individual/family work through providing support and counselling services in a flexible and non-judgmental approach. It used a balance of drop-in and fixed appointments for clients.

In relation to its work in integrating services the team were engaged in:

- hospital liaison with the GUM clinic at St. James's;
- liaising with GPs by making them aware of the RCDT, promoting the community based approach, providing advice and support exploring the possibility for prescribing options. It had been planned to involve GPs more in the RCDT, in meetings of the consultative forum. By this stage, sound links had been made with one local practice;
- networking with other services both voluntary and statutory as a means of increasing collaboration and integration.

In relation to its commitment contained in the mission statement the team had developed consultative forum meetings to allow the community to have an input into the continued

development of the team. There was also collaboration with other community groups in terms of constructing local development plans.

As a means of evaluating the project it had been proposed that a database would be developed for recording client information in a confidential manner. Also, the RCDT had anticipated that they would attract research funding and would have self-evaluation mechanisms within the team.

By autumn 1995, the team has made steady progress. A deliberate strategy of consolidating what already had been gained had been undertaken by the management team. It has been effective in developing a local response to the needs of drug users and it has firmly established itself within the local community. The main activities revolve around the drop-in and counselling service. Attendees come for some informal interaction with staff and others and, where appropriate, engage staff more formally in relation to specific issues or to seek counselling. The main focus of counselling is to reassure attendees, develop their confidence, self esteem and their capacity for decision making and to assist in making contact with appropriate medical and other services. On a weekly basis the team has 80-90 separate contacts with its client group and sees 3-4 new referrals. A number of additional support activities which support the client group also take place including art, reiki relaxation, aromatherapy, memorial quilt group, family support group, prison and hospital visitation.

The team is engaged with other workers, community projects and professionals as part of its broader networking activities. Specifically, the team has links with :-

- EHB AIDS/HIV outreach worker;
- a small number of general practitioners;
- the South Inner City Treatment Services Group;
- Community response;
- in the community the team is involved with the Rialto Network, the Budgeting project, Task Forces in Dolphin House and Fatima flats.
- the addiction counsellor from the RCDT represents the EHB on the Board of the Bluebell, Inchicore, Islandbridge, Kilmainham, Rialto APC

The RCDT has been involved in consultations in relation to the establishment of clinical facilities for drug users in the South Inner City and it has also contributed to the development of a sympathetic view in the community towards the provision of local services in both

Dolphin House and Fatima Mansions. The South Inner City Treatment Services Group (SICTSG) has evolved over the past 12-18 months in which the RCDT has played an important role. The SICTSG group has been involved in consultations with the Eastern Health Board in relation to the establishment of clinical services and a network of CDTs in the general South Inner City area.

In October 1995, the RCDT conducted an internal/self-evaluation which while noting the achievements made in the three years of its existence, engaged in a critical appraisal of its own development. In a report on this process the team noted a number of crucial points:

Contact with GPs lack clear structure primarily because demand for services of practitioners outstrips supply. Over use of a small number of GPs by drug users limits the possibilities of developing more involved working relationships and therapeutic programmes.

- There was concern that the drop-in facility played too central a role in the RCDTs activities. The emphasis on accessibility and informality created situations whereby the team could not provide all attenders with protection (from pressure to buy or use, and from being caught up in the chaos of others) to which they were entitled. The team introduced restrictions in drop-in times which led to an improvement in the management of the facility.
- This situation raised the issue for the team as to whether they were challenging enough in terms of offering self-contained rehabilitative programmes. The team refers to and acknowledges that it has yet to develop community-based forms of rehabilitation and reintegration.
- The RCDT has not made significant impact on the integration and co-ordination of clinical services to drug users. The team consider this to result from external factors such as the non-availability of a district clinical service and the fact that the team does not have as designated members, general and other community care staff.
- There is no team leader. The counsellor, because he has worked there longest, assumes many of the co-ordinating responsibilities. This places pressure on the work given that the counsellor carries a caseload¹.

¹ Since this report was completed the RCDT received sanction to appoint a team leader. This position was filled in October 1996.

- There is concern in relation to the needs of children of drug using parents. In this context the team has been involved in working group to develop proposals for the establishment of a support service for families.

At this point, there are significant pressures placed on existing staff and resources in the co-ordination and management of its activities. These stem from the slow development of the wider district level services, the absence of a scheme for GPs to assist in the overall management of the problem, and the lack of integration. The RCDT has risen to the challenge with the resources it has and has perhaps stretched these too far. It has not, based on its own reflection, achieved integration, but it has laid the groundwork for this.

The RCDT is also confined in its development owing to the small space in its premises and the current level of human resources available. The management committee has proposed that the EHB would fund the appointment of a Team leader who would have responsibility for the direction of day-to-day programmes, to create the process for expanding the RCDT, to negotiate the introduction of clinical services for drug users, to develop initiatives around the needs of children of drug-using parents, and to report to the management committee.

4.3. THE ROLE OF THE RCDT IN RELATION TO BROADER DEVELOPMENTS IN THE SOUTH INNER CITY AREA.

In 1994, a Task Force was established in the Dolphin House flat complex which had representation from a range of agencies including the local development group, the EHB, Dublin Corporation, City Councillors, Gardai. The agenda tended to be dominated by the supply aspects of the problem. The RCDT helped to place the issue of treatment and rehabilitation on the agenda. Once the treatment issue gathered momentum it led to a meeting with the Chief Executive of the EHB. The issue at stake at the time was the fact that there was no places in treatment centres for clients from Rialto. At the time of its initial start-up, the RCDT were referring only one case per week to the EHB addiction services at Baggott Street, and at this stage, these referrals had ceased.

At a further meeting, the development of local treatment services was discussed and the option of siting these at Weir House on Cork Street or at St James's Hospital was presented. The development of more locally based treatment services would solve a problem for the EHB – getting local people to accept treatment facilities. The RCDT along with community activists from Dolphin House engaged in a consultative process following this and a wider

group began to emerge which included members of Community Response and local groups from around the South Inner City. This broader group took on a life of its own and called itself the Treatment Services Group (SICTSG). Ongoing representation of the RCDT is channelled through the community drug worker who is a member of SICTSG.

The RCDT has played a crucial role not only in the development of this group but has had a significant influence on the agenda. It has done so by creating an awareness of the CDT model which has served to inform the development proposals now being brought forward by the SICTSG and which were discussed with the EHB. The proposals have received broad acceptance and are now being implemented. A management committee has been established with community and statutory representation with the specific brief of recruiting and supporting a development officer to establish other CDTs in the South Inner City.

The specific proposals being brought forward by the SICTSG argue for a number of dispersed clinics offering treatment, supported by three or four CDTs in priority areas. The EHB are interested in CDTs and have been favourable in this regard but have yet to find a way to involve the local community in the management of the treatment facility. While the EHB has accepted partnership vis a vis CDTs, it is not prepared to embrace this concept for clinical treatment. For the SICTSG, the clinical response which is managed alone by a medical hierarchy, is anathema to community development. Nevertheless, a compromise model could be accommodated by a 'partnership' approach which would give the local community an input into the planning and management of services. This could present the EHB with new possibilities for gaining legitimacy and credibility which would potentially strengthen the delivery of services. This key tension is yet unresolved and led to a feeling within the SICTSG that the agreement by the EHB to develop CDTs is, rather than being an outcome to revel in, a soft option for the health services. The implementation of the EHB's clinical response is, for the SICTSG, not up for negotiation.

4.4. KEY ISSUES FOR THE RCDT

1. The broader range of treatment options which were part of the 1991 Government Strategy have yet to be developed especially in relation to general practitioner prescribing. This limits the extent to which any community based response can be mobilised. The RCDT has taken the CDT model to the outer limits within the parameters of an incomplete policy framework and the uneven introduction of treatment and rehabilitative services.

2. The issue which motivated the RYP to engage with the EHB is still the key problem on the RYP agenda – i.e. lack of treatment options.
3. The RCDT has no formalised link with local GPs or with the clinical services. Those referrals which are made have been largely due to the extent to which individual members of staff have used their personal influence to persuade services to accept clients. Contact with GPs is limited and confined to willing doctors as opposed to formalised links with those within its catchment.
4. The RCDT has successfully established itself within the local community through its strategic engagement of the community in the policy making process.
5. The lack of treatment places and treatment options consequently implies that few drug users have access to the resources needed to facilitate their stabilisation. This stabilisation is essential to developing the RCDTs rehabilitative and reintegrative potential. The current level of physical and human resources limits the capacity of the RCDT to respond to challenges and identified needs.
6. The RCDT has played a strategic and significant role in creating a broader community response which has promoted a ‘pro-user’ ethos. More significantly, through networking and linking with community groups in the broader south inner city area, it has been in a position to create awareness about the CDT model which in turn has been fully accepted as a rational and creditable response. Thus, the RCDT has been influential in generating a treatment debate leading to a more constructive focus on the issues.
7. The local drug service for drug users and their families has been significantly developed by the RCDT. Based on its own internal evaluation the team recognise the need and scope for further development. The RCDT also acknowledges the need to focus on the adoption of strategies to achieve integration of services and greater involvement of GPs. This can only be achieved within the framework of national policy but might be expedited by additional staffing to concentrate resources on strategic integration.
8. The potential for rehabilitation and integration is enhanced by the introduction of an Area-Based Partnership Company to the area. This creates an opportunity to focus on

- the training needs of stabilised drug users and on employment and enterprise initiatives with this group.
9. Children of drug using parents are especially at risk. It is a developmental priority now for the RCDT but it has resource implications.
 10. The model proposed by the 1991 Government Strategy document can be potentially realised through the expansion of the team to include those professionals who can make a strategic input to meet needs – especially social workers, public health nurses, general practitioners and probation services. These service personnel need to be incorporated as part of the team for the purposes of integration and co-ordination and not just as occasional visitors to facilitate liaison.
 11. The RCDT needs to incorporate a primary health care input if the integrated model is to be completed. The team currently has no clinical or primary health care component.

5. CONCLUSION

5.1. PUBLIC HEALTH MODEL, HEALTH PROMOTION AND COMMUNITY DEVELOPMENT

In describing the evolution of public policy in relation to drug services and the general health services, it must be noted that services for drug users are being planned with a public health model. This model is centrally planned by a medico-administrative hierarchy and implemented by a range of professionals who are vertically integrated within that hierarchy. Thus, the public health model bolsters and reproduces the existing power structures. In developing policy, the public health model can at best consult with what it defines as the community. Decision making in this context is the reserve of those at higher levels within the bureaucracy.

Both the Health Strategy and the Health Promotion Strategy as introduced by the Department of Health in recent years is symptomatic of a shift to a new public health model which is more participative than the old. The endorsing of the Ottawa Charter thus gives rise to an essentially new approach which emphasises individual change and communal action; which is less reactive and reorients health services to promote 'positive health'. The Ottawa model provides a principled framework which will allow for a sharper focus in public health services. While the model has been embraced by Government at the level of rhetoric it may run into difficulties at the level of implementation within health boards. The Eastern Health Board itself does not have a clean record when it comes to collaborative initiatives in the drugs area. For instance, Cullen's (1993) case study illustrates clearly that previous failed attempts at concentration between the Board and community groups reflected a disjunction between the rhetoric and reality of community care as espoused by the public health authority.

The RCDT has taken the CDT model and generated a community development approach. In this sense it has added to the model its own unique contribution. As outlined in section two of this report, the UK CDTs did not have this component. The community development model seeks to develop a 'process' oriented approach which stresses group learning, participative democracy and consciousness raising. It develops horizontally linked networks, unlike the public health model which is vertically linked to the decision making structures of the State.

As a partnership between the EHB as proponents of the public health model and the RYP which is firmly rooted within the local community, the RCDT provides a clear focus for

health promotion. It is also a locus for the new public health approach in that it integrates a community development with a new public health function. The integration of both models will take a process of evolution involving compromise and mutual respect. It can achieve this by strengthening the partnership and broadening the inputs to deal fully with the problematic nature of drug use.

5.2. COMMUNITY PROCESS AND POLICY FORMULATION

The RCDT through its commitment to ongoing consultation and participation of the community has developed a process which is inclusive policy making in action. It acts as an example of how this can be achieved by all public institutions. The RCDT is a means of deepening participative democracy in that it sets up feedback mechanisms between the management committee and those who live in the community with which it services. The small local base enhances the potential for direct engagement and further promotes participation. Unlike the UK CDT model where one team can operate in an area with a population in excess of 300,000, the RCDT is in a better position to perfect its approach. The local base of the RCDT allows it to have its ‘finger on the problem’. It is in an ideal position to identify shifts in the problem, identify trends and needs and tailor a response. Thus, the model serves as an effective and responsive way of formulating and implementing social policy.

5.3. IMPLEMENTING AND PERFECTING THE INTEGRATED MODEL

As highlighted in section 2 of this paper, the integrated model as proposed in the ACMD (1982) report was not fully implemented as the primary health care providers did not become involved. An integrated model thus requires all of its components to be in equilibrium for it to be effective. Irish public policy has borrowed much from this experience, albeit that in the 1991 Government Strategy the ACMD was not referred to. Only one CDT is operational in Ireland and has yet to develop the components and supports envisaged for it in. Government policy. The absence of GP prescribing and the lack of district based decentralised services has meant that the RCDT has at best been operating way below its potential.

Nevertheless, the RCDT has taken the CDT model to its extreme within this context. It has, by default to some extent, created the conditions which may help it to avoid the ‘reproduction of the specialist at local level’ as in the UK experience. In this way, it has advanced the

integrated model by developing a broadly based community support which gives it credibility and legitimacy within its area.

CDTs in the UK, especially those with designated medical input, were successful at attracting users into treatment. The RCDDT could take its own services a step further if it had such a designated medical input in the form of a clinical assistant operating within the team on an equal basis with other members. Such an input would only be useful in the context of local GPs becoming involved. The latter prospect is a matter for the public health authorities and the medical representative bodies, as well as individual practitioners, to ensure.

The 1991 Government Strategy and the Health Strategies have created the framework for new possibilities for community based drug services. The current policies and services being developed by the Eastern Health Board are in line with that strategy. The RCDDT is an example of the working ethos of intersectoral collaboration. Nevertheless, the EHB has yet to develop any clear strategy for including local communities in the management and policy formulation for local drug services. The CDT provides an ideal locus to develop this but it could also extend to other treatment and rehabilitation services.

5.4. KEY POINTS FOR INCREASED COLLABORATION

- (i) In keeping with the 'health development sectors' principle of the Health Strategy, the Eastern Health Board could broaden the range of actors involved in policy making. Its strategy group would benefit from the input of those working within policy at local level.
- (ii) While the Health Boards are the responsible bodies to implement Government demand reduction policy, there is no overall co-ordinating agency with the responsibility to integrate policies. The National Co-ordinating Committee could be established as a statutory body with a broad based intersectoral membership to build on current policy, evaluate the effectiveness of these and to pilot new and innovative models. This committee or other suitable alternative, if modelled, for instance, on the UK Advisory Council on the Misuse of Drugs, could help fill the very serious policy vacuum that tends to persist in drug treatment policies and developments.

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