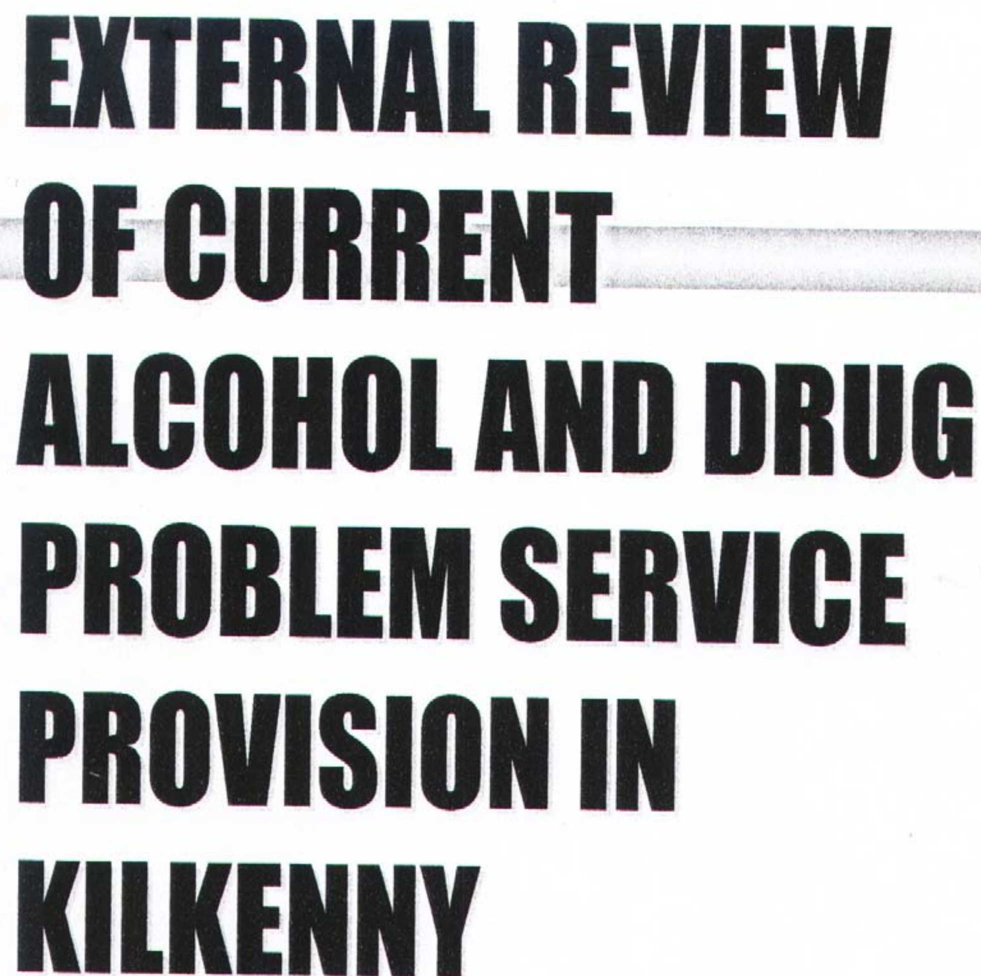

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We also kindly acknowledge the clinical staff from the CATS, Kilkenny, their provision of service activity statistical reports**.**

PURPOSE

This report was requested by the Regional Coordinator and was aimed to be a rapid assessment with background reading, a two day visit to the service and to meet with key stakeholders, and the preparation of a draft report that would be subject to discussion and consultation.

This report is the product of a focused, rapid, external appraisal of the Community Alcohol Treatment Service (CATS) based in St Lukes in Kilkenny. As part of me review the provision of services in towns in the area were also considered and the review thus contains several systemic observations and recommendations. The aim of this review was to assess the current organisation and level of treatment provision and make comments on how this service could best move forward and respond to the recommendations of the Regional Treatment and Rehabilitation Working Group (2001). The recent publication of the National Drugs Strategy allowed for the opportunity to explore further how regional strategy on treatment services could be further). developed as part of the overall national drugs strategy(Irelands National Drug Strategy 2001 - 2008

The following are the overall strategic aims of the Strategy

OVERALL STRATEGIC AIMS OF NATIONAL STRATEGY

- To reduce the availability of illicit drugs
- To promote throughout society a greater awareness, understanding and clarity of the dangers of drug misuse
- To enable people with drug misuse problems to access treatment and other supports in order to re-integrate into society
- To reduce the risk behaviour associated with drug misuse
- To reduce the harm caused by drug misuse to individuals, families and communities
- To have valid, timely and comparable data on the extend *and* nature of drug misuse in Ireland and
- To strengthen existing partnerships m and with communities and build new partnerships to tackle the problems of drug misuse

APPROACH TO PREPARATION OF REPORT

This report builds on background documentation provided to the consultants on needs assessment activity undertaken in the recent past. This includes a summary report of activity of the Community Addiction Treatment Service in Kilkenny and other protocols procedures and assessment forms, a Report on the Kilkenny Drugs Initiative; Substance Misuse Research and Findings Action Plan, Rosemary Finane, The Regional Treatment and Rehabilitation Working Group Recommendations. Background reading was also helped by a thesis by Johnny Casey; On an evaluation of the development of the community alcohol treatment services in the South Eastern Health Board Area, Finally the recently published National Drugs Strategy has shaped the structural recommendations of this report.

In addition to the review of background documentation brief interviews were conducted with key stakeholders from the key areas involved in the current delivery of the CATS and to the future planning of service change and development.

Key informant interviews included the following individuals:

Mrs. Angela Parker – Family Support Group
Mr. John Murphy – Probation Service
Dr. Louis Calvert – Consultant Psychiatrist
Mr. Bobby O Brien – Addiction Counsellor
Mr. Mark Downey – Addiction Counsellor
Mr. Tony Barden – Regional Drug Co-ordinator
Dr. Mary Mooney Consultant Psychiatrist
Dr. A.N de Souza – Public Health Specialist
Mr. Michael Kiwan – The Director of Nursing

STRUCTURE OF THE REPORT

This report provides a summary of the background needs assessment, a contextual description of current national trends in substance misuse problems and trends in the organisation of services to respond to such problems. Assessment of current levels of provision and recommendations about future development of service organisation and service delivery.

BACKGROUND

In the past decade there have been significant social changes in Irish Society. In particularly there has been growing affluence, growing secularisation of society and a growing awareness of a significant alcohol and drug problem among young people. Substance Misuse services with a focus on drugs and in particular on opiates were extensively developed in the Dublin area over the past decade. The drug problem however has not remained confined to the Dublin area and there is increasing concern around the spread of illegal drug use to rural and other metropolitan areas. To this end the recently published National Drugs Strategy recommends the development of a more co-ordinated drug service in all parts of the country. These services should ideally be

focussed on young people and be part of an integrated approach to alcohol and other illegal drugs. These recommendations are commensurate with previously published recommendations of the Regional Treatment and Rehabilitation working group.

Research findings from the Kilkenny Drugs Initiative estimated through qualitative and semi-quantitative work that there were substantial levels of availability of cocaine, ecstasy, magic mushrooms, but more limited availability of cocaine, and heroin but that such drugs were available. They also noted the major place of alcohol within the general society but also that heavy drinking was part of the drug taking culture. There was a clear identification that such patterns of drug use were having a negative impact on some of the persons involved and also on parents and communities involved and that this represented a significant challenge and threat to the community.

Overall both national and local studies indicate a general upward trend in consumption of both legal and illegal drugs. A survey carried out by the National Youth Council of Ireland indicates that 53% of young people have tried an illegal drug. A survey by the Mid Western Health Board demonstrated that just under one third reported use of at least one illicit substance. Cannabis was the most commonly reported illicit substance followed by the use of inhalants. The European School Project on Alcohol and other Drugs (ESPAD) is a cross European schools survey conducted in 1999 and published in 2001. Results indicated that levels of involvement with alcohol, tobacco and other drugs were comparatively higher in Ireland than in most European countries.
Surveys on tobacco and alcohol have been conducted as part of the National Health and Lifestyle Surveys and published as the HBSC/SLAN report (1999). This reports indicates a significant change in patterns of alcohol consumption with a higher percentage of males and females of all ages reporting regular alcohol consumption and that in particular that consumption is becoming more regular among young males and females. Overall consumption of alcohol is greatest among the males in the l8-34 age bracket, among semi-skilled and unskilled individuals. The SLAN survey reports that 31% of the Irish adult population smoke. Of the 31% who smoke the majority (39%) are within the 18-34 year age group. Early school leaving is associated with increased levels of involvement with tobacco, alcohol and other drugs. It is widely recognised that individuals who are socially marginalized through homelessness, imprisonment or other forms of social exclusion are at significantly greater risk of involvement with tobacco, alcohol and other drugs.

The services identified as responding to drug problems were Aislinn Adolescent
Treatment Centre, Ballyragget; St Canices Hospital Kilkenny; Community Alcohol
Treatment Service, St Lukes Hospital Kilkenny; The Samaritans phone line;
Alanon/AA; Primary Care Services; Aiseri-Cahir Tipperary/Wexford,
Waterford-Accept Addiction Treatment Service, Carlow-Community Alcohol
Treatment Service, Wexford-Counselling Service
Tipperary-South Tipperary Alcohol and Addiction Service
The gaps identified within these services was that there was a need for co-ordinated integrated user friendly service which needed to be a joint effort from all services.
These components needed to comprise of Prevention, Intervention, Treatment,
Aftercare, Publicity and Media and Management.

In the context of treatment it was stated that there was a need for more accessible treatment, community addiction counsellors for families and youth especially under 18s and that existing treatment services needed to be better resourced and to engage in more public relations work around their own activities.

The Regional Report on Treatment and Rehabilitation recommends a move towards community based treatment and the development of a service that has the capacity to follow up clients who have chaotic lifestyles and are also at risk of self harm. The core of this service would be primary care led with a designated key worker system to co-ordinate care of the client and review progress and plans and this would occur in the context of a three tier level of service with primary care, secondary care and tertiary care level of interventions being provided.
The key recommendation following on from this is the development of a substance misuse unit headed by a team leader/Manager in each community care area. The specialist psychiatric services have an important role in the assessment and treatment of persons with co-existing drug misuse and serious mental disorder. There is a need for a partnership approach for the provision of prevention, treatment and aftercare programmes that ensures that all the disciplines are included and mobilized to commit themselves to the challenge of making the new service function as effectively and as efficiently as possible.

The overall direction or these recommendations is consistent with the national drug strategy and is also consistent with international trends in the development of community based services for substance misusers.

TASK FOR CURRENT REPORT

To look at the current service provision within CATS and to consider how existing service can be adapted to meet regional strategy.

Site Visit to St Lukes Hospital CATS headquarters

The CATS was established in 1990 as a direct result of the recommendations of the mental health strategy document, Planning for the Future. In essence this approach promoted a shift from an in-patient approach to a community based approach to the treatment of alcohol problems. This service was established by Dr Louie Calvert with a small core team. Her input to this was only a very small part other overall clinical responsibilities. Despite the limited time available she supported and encouraged the ongoing development and day to day input to this service for over a decade. It is worth noting that Kilkenny is fortunate to have a general psychiatrist who has developed a special interest in this topic.

The service had two counsellors for many years and had more recently acquired a third counsellor. The service has input half time from a Non Consultant Hospital doctor at registrar level.

The service has operated from a single floor in an outpatients' building on the St Lukes site, in Kilkenny since 1990 (or thereabouts). There are approximately four counselling rooms and 4 offices in the facility. There has been no change or development or growth in the actual physical facilities through the decade of its existence.

There is no directly provided administrative support and the counsellors essentially manage all aspects of receiving, assessing, and counselling their own caseload. The consultants were left with the impression that the service is "run on a shoestring".

Referrals are taken at any time during office hours and sometimes from evening sessions. It was estimated that approximately 5 new cases a month are referred to the service. Officially, a day services is provided (09.00-17.00), but demand from clients in employment or with other responsibilities has led to a number of evening counselling sessions being provided on a individual needs basis.

Dr. Calvert has immediate clinical and managerial oversight for the alcohol and substance misuse counselling service based at the St Luke's hospital site. Originally providing 3 hours (0,5 sessions) per week of direct contact to the service, during the past 5 years this has reduced to 1.5 hours (0.25 sessions) per week on a job share basis.

Counsellors are accredited or linked with tile Irish Association of Alcohol and Addiction Counsellors (IAAAC). The counsellors appear to carry significant levels of responsibility as key workers and as clinical decision makers.

The overall level of activity over the previous three years was 120 to 130 new cases per year. The staff felt that they worked hard and responded to demand as it presented. The average number of attendances were approximately 10 per case. It is assumed that this would include a significant number of shorter and a small number with prolonged attendance. Overall given the size of the staff and the range of tasks they were required to undertake and the lack (if administrative support and the default rate in such services this represents a reasonable level of activity.
However given the fact that this is the only service of its kind available it indicates that the level of penetration of the service to the broader community must be quite limited.

The counsellors stated that they were prepared to take walk- in assessments but the service was not structured in a manner that would facilitate such a service and in practice there were on average three self referrals a month. The service workers stated that liaison and support to the other parts of the hospital and psychiatric service was an important component of its service. However in the two previous years there were approximately 2 referrals a month from St Canices'. On average over the previous two years there had been one referral a month from a general practitioner. The documents provided to us indicate that the service attempted to make links with a range of other community agencies, including the voluntary sector, the probation service, primary care and others. However given the small size of the staff, the lack of administrative support and the need to maintain the core service it is hard to sec how any substantial amount of

time could be devoted to the important task of community liaison and building up a broad network of community links.

Organisational Change

The development of a new integrated community based service will involve some significant organisational change where some of the current mental health service activity will be integrated with other community based services. See organisational chart appendix 2. This offers the opportunity for better interagency activity but will also require sensitive management to ensure that the current range of slake holders are encouraged and motivated to work to have significant involvement and influence over the development of the new services.

Improving service delivery

We suggest that the key to improving service delivery in the region should be undertaken by:

- Ensuring that people with alcohol and other drug problems can access services which are appropriate to their needs;
- Ensuring the delivery or access to a range of primary, secondary and tertiary health and social care across generic and specialist providers;
- Ensuring the delivery of care co-ordination based on a continuing assessment of presenting and evolving treatment and support need, in order to match a person with an alcohol or other drug problem to appropriate treatment interventions and support systems.
- Planning on building capacity through partnerships with the range of community agencies that are potentially dealing with the same target population.

Care co-ordination

We suggest that effective care co-ordination has the following characteristics:

- Screening and triage (priority assignment of patient to treatment response) and regular assessment of the health and social care need;
- Identification of a care coordinator to ensure the appropriate, timely and effective delivery of treatment and support services;
- Development of a risk assessment and treatment and care plan with the patient, which contains individual goals, clearly specified problem levels which amenable to further measurement to record progress;
- To develop contingency and crisis management plans for the patient with complex needs, as required;

Integrated Care Pathways

We recommend that a working group be established to prepare and Integrated Care Pathway (ICP) framework for the operation of the alcohol and drug treatment provision in the area. ICPs are known by various names, including critical care pathways,

treatment protocols, anticipated recovery pathways, treatment algorithms, care standards and benchmarks. All of these are designed to create professional consensus and standardise elements of care to improve efficiency, effectiveness and value for money. Essentially, an ICP describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. The development of ICPs in the substance misuse field is recommended fur several reasons:

- Substance misusers may have multiple problems which require effective co-ordination of treatment;
- Several specialist and generic service providers may be involved in the care of a patient;
- A patient may have continuing care needs requiring referral to a different treatment and support service over time.

Monitoring service delivery

We recommend that: a working group should also he established to oversee the development and implementation of enhanced arrangements for monitoring the delivery and impact of treatment. We suggest that these arrangements should cover both output and outcome monitoring. Output monitoring reports on activities and processes performed by those providing treatment services. Outcome monitoring reports on the results or impact of activities and processes upon a person receiving a treatment service.

These recommendations are founded on the following suggested principles:

1. Establishing a system of routine output monitoring of treatment services in the region should be a priority;
2. All relevant treatment services must participate in the National Drug Treatment Reporting System (NDTRS);
3. The reporting requirements placed on treatment providers must be kept to a minimum;
4. Outcome monitoring should be based on a small set of clear, unambiguous and national drug strategy relevant indicators;
5. In most cases, properly resourced research groups should gather information on post-treatment outcomes.

1. **Establish a treatment service information strategy.**

The Commissioners should review the nature and scope of information about treatment services that is currently reported under contracts and other service agreements. The review should assess levels of compliance across agencies and also assess the utility of questions asked for the commissioner. The aim should be to simplify the monitoring m formation required.

2. **Establish a basic output monitoring system**

The Commissioners should work towards a reporting system that collects a minimum dataset from treatment agencies in their area. At this stage, the following

is offered to illustrate the thinking of the agency. The reporting framework may be revised in the light of consultation.

> For a reporting period (e.g. the past 6 months'), (he total number of people who:
>
> 1. Were referred for assessment;
> 2. Completed assessment;
> 3. Were waiting to begin treatment and the average duration of wait at the reporting point;
> 4. Began treatment;
> 5. Left treatment; and
> 6. The average duration of treatment.
>
> This information should be stratified by the following:
>
> a. Gender;
> b. Age group (e.g <18 years and 18+ years);
> c. Ethnic group (2001 Census coding);
> d. Treatment categories
>
> As a single outcome indicator, file commissioners should explore how all agencies in their boundaries can submit reliable returns on [lie following:
>
> Of the total number in (5) above, a summary report of the number of cases in which treatment was:
>
> Completed (against care plan);
> Completed and transferred to another level of care ('specified)
> Term mated due lo breach of contract;
> Terminated because client left/dropped out
> Terminated because client sent lo prison
> Terminated for another reason (specified)

In addition, the introduction of a basic clinical outcome monitoring system to monitor change during treatment is advocated. There are several developed instruments which can be used and a thorough appraisal of These exceeds the remit of the current review. The Maudsley Addiction Profile (MAP) - which has been developed by the consultants – is shown in the Appendix 1 for information, incorporation of the MAP for an enhanced version to meet local needs will require a developmental plan which can be overseen by the working group.

<u>Overall recommendations</u>

1. The service commissioners should review the funding arrangements for the provision of alcohol and drug counselling and service provision. The development of an integrated community based service is the best way to harness new resources and develop and innovate on the basis of current funding opportunities.

2. Improved service integration and care pathways should be used to enhance the efficiency and effectiveness of local service provision.

3. Medical advisors should assist the local Probation service to establish a drug testing protocol – sample type, handling procedure, testing method, results interpretation and reporting.

4. There should be an increase in the psychiatry input to the Kilkenny and Carlow services – to a minimum of 2 sessions/week.

5. A regional committee structure providing strategic oversight report needs to be mirrored in each service provision area. This needs to be linked to and in good communication with the regional drugs coordinator.

6. An advisory panel needs to he set up in each of the 5 areas, with line reporting to the commissioning management structure.

7. An audit of the therapeutic skills and competencies of alcohol counsellors should be undertaken and a training and development programme instituted as required.

8. Counsellor supervision or case-load should be provided within the management Structure,

9. We do not consider that it is reasonable for the S.E. Health Board to be expected to meet the costs of external personal clinical supervision of alcohol counsellors. This should be met by the individual if desired.

10. The S.E. Health Board should establish a developmental plan to ensure that a multidisciplinary team structure underpins each of the 5 service areas. This should include counsellors, nurse trained counsellors.

11. Access to counselling provision should not require an initial assessment by a psychiatrist. Risk assessment, procedures should identify those who require specialist mental health assessment and input.

12. All clients should receive a medical assessment if they request it or if the assessing worker considers that this is required.

13. Public health issues linked to the diversion of benzodiazepine prescriptions from patients to other users should he investigated and tackled accordingly.

14. There needs to be a clear line of managerial accountability and reporting within the system.

15. There should be further development of voluntary sector provision of advice, and information - in particular targeted at young people in the area. The development of services for young people should be done with a clear knowledge of the experiences and difficulties faced locally, nationally and internationally in shaping such services in an effective and cost effective manner.

16. The development and implementation of enhanced output and outcome monitoring arrangements should be a priority.

APPENDIX 1

MAUDSLEY ADDICTION PROFILE (MAP)

SECTIONA: MANAGEMENT. INFORMATION

Include the study specific information as required (e.g. participant identification, programme codes: interview point)

SECTION B: SUBSTANCE USE

None	1 day only	2 days only	3 days only	1 day a week	2 days a week	3 days a week	4 days a week	5 days a week	6 days a week	Every day	Some other number
0	1	2	3	4	9	13	17	21	26	30	

Oral	Snort/sniff	Smoke/chase	Intravenous	Intramuscular
1	2	3	4	9

a. Enter number of days used in past 30 days [Card 1] – enter "0" for no use;
b. Enter amount used on a typical day in the past 30 days [verbatim]
c. Record route(s) of administration [Card 2]

SUBSTANCE	DAYS USED	AMOUNT USED ON TYPICAL DAY	ROUTE(S)
B1. Alcohol			
B2. Heroin			
B3. Illicit methadone			
B4. Illicit benzodiazepine		Drug:	
B4. Cocaine powder			
B5- Crack, cocaine			
B6. Amphetamine			
B7. Cannabis			
B8. Other:			
a.			
b.			
c.			

SECTION C: HEALTH RISK BEHAVIOUR

If no illicit drugs injected in the past 30 days, skip to sexual behaviour questions

C1. Days injected drugs in the past 30 days **[card 1]**		Days
C2. Times injected on a typical day in the past 30 days		Times
C3. Times injected with a needle/syringe already used by someone else		Times

If no penetrative sex in the past 30 days, skip to Section D

C4. Number of people had sex with and not used condom		People
C5. Total number of times had sex with and not used condom		Times

SECTION D: HEALTH SYMPTOMS

Never	Rarely	Sometimes	Often	Always
0	1	2	3	4

D1. How often experienced the following physical health symptoms

	Never (0)	Rarely (1)	Sometimes (2)	Often (3)	Always (4)
a. Poor appetite	❒	❒	❒	❒	❒
b. Tiredness/fatigue	❒	❒	❒	❒	❒
c. Nausea (feeling sick)	❒	❒	❒	❒	❒
d. Stomach pains	❒	❒	❒	❒	❒
e. Difficulty breathing	❒	❒	❒	❒	❒
f. Chest pains	❒	❒	❒	❒	❒
g. Joint/hone pains	❒	❒	❒	❒	❒
h. Muscle pains	❒	❒	❒	❒	❒
i. Numbness/tingling	❒	❒	❒	❒	❒
j. Tremors/shakes	❒	❒	❒	❒	❒

D2. How often experienced the following emotional or psychological symptoms **[card 3]**

	Never (0)	Rarely (1)	Sometimes (2)	Often (3)	Always (4)
a. Feeling tense	❒	❒	❒	❒	❒
b. Suddenly scared for no reason	❒	❒	❒	❒	❒
c. Feeling fearful	❒	❒	❒	❒	❒
d. Nervousness of shakiness inside	❒	❒	❒	❒	❒
e. Spells of terror or panic	❒	❒	❒	❒	❒
f. Feeling hopeless about the future	❒	❒	❒	❒	❒
g. Feelings of worthlessness	❒	❒	❒	❒	❒
h. Feeling no interest in things	❒	❒	❒	❒	❒
i. Feeling lonely	❒	❒	❒	❒	❒
j. Thoughts of ending your life	❒	❒	❒	❒	❒

SECTION E: PERSONAL/SOCIAL FUNCTIONING

If <u>not in a relationship in the last 30 days</u>, skip to relatives questions

E1. <u>Days had contact</u> with partner in the past 30 days [card 1] — Days
(ie. say them or talked on the telephone)

E2. <u>Number of these days</u> were there was conflict with partner — Days
(ie. Had major arguments)

<u>If not relatives or any contact with relatives in past 30 days</u>, skip to friends questions

E3. <u>Days had contact</u> with relatives in the past 30 days [card 1] — Days
(ie. Say them or talked on the telephone)

E4. <u>Number of these days</u> were there was conflict with relatives — Days
(ie. Had major arguments)

If <u>not friends or any contact with friends in past 30 days</u>, skip to Section E7

E5. <u>Days had contact</u> with friends in the past 30 days **[card 1]** — Days
(ie. Say them or talked on the telephone)

E6. <u>Number of these days</u> were there was conflict with friends — Days
(ie. Had major arguments)

E7. Number of days of paid work in past 30 days [**card 1**] — Days

E8. Days missed from work became of sickness or unauthorised absence in the past 30 days — Days

E9. Days formally unemployed in the past 30 days — Days

Selling drugs	Fraud/forgery	Shoplifting	Theft from a property	Theft from a vehicle	Theft of a vehicle	Other crimes

E10. Crimes committed in the past 30 days [card 4 and card 1]

	Days committed **[card 1]**	Number of times committed on a typical day **[card 2]**
a. Selling drugs		
b. Fraud/forgery		
c. Shoplifting		
d. Theft from a property		
e. Theft from a vehicle		
f. Theft of a vehicle		
Other crimes:		

END OF INTERVIEW

APPENDIX 2