

**DRUG and ALCOHOL
DETOXIFICATION SERVICES
A NEEDS ASSESSMENT for
CORK and KERRY 2005**

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FOREWORD

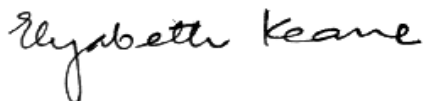
Colleagues,

The misuse of Alcohol and Drugs is one of the most significant threats to public health in this country at this time. To tackle this rising epidemic there is an urgent need to implement national policy, including the need to ensure effective treatment services are available for those affected by alcohol and other drugs of misuse.

This research specifically assesses the need for detoxification services in the Cork and Kerry region.

The excellence of the research and the rigour with which it was conducted are a tribute to the Principal Researcher, Dr. Mai Mannix, Specialist Registrar in Public Health Medicine.

It will prove extremely valuable in informing the planning and delivery of services in the region and in so doing will help to curb the epidemic and improve the health and quality of life of the people of Cork and Kerry.

A handwritten signature in black ink that reads "Elizabeth Keane". The signature is written in a cursive, flowing style.

Dr. Elizabeth Keane
Director of Public Health

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EXECUTIVE SUMMARY

Background: During recent years there has been growing concern about the increase in alcohol and drug abuse in Ireland. Treatment services are an important aspect of a multi-faceted approach to drug and alcohol problems. In the provision of treatment services detoxification plays an important role. The Drug and Alcohol Committee of the Southern Health Board (now Health Services Executive – South) commissioned this study to estimate the need for alcohol and drug detoxification within the region.

Methods: The current evidence base for best practice in drug and alcohol treatment including detoxification is reviewed in the literature. International best practice as regards models of care for these services are also summarised. The needs assessment employs a number of different approaches. Epidemiological data examined included mortality and morbidity data. An estimate is made for detoxification services using a systems-based approach and indirect methods of estimating prevalence of opiate misuse are summarised. Comparisons were made between detoxification services Cork and Kerry with detoxification services for alcohol in Barnet, London. The current services for detoxification from opiates were compared with services in other regions in Ireland. Current treatment services are summarised. The views of the main stakeholders were obtained using qualitative (interviews) and quantitative (questionnaires) methods. In-depth interviews were held with a range of health service providers and a number of health service users. Questionnaires were also circulated to a range of health service providers.

Findings: 65% of professionals reported difficulty accessing services outside their own service for alcohol detoxification. There was a high level of dissatisfaction with current service provision among health service providers, both in terms of access to inpatient detoxification and ongoing links into treatment services. Services are fragmented with poor liaison between services. All professional groups gave highest ranking to a specialist detoxification unit as the most appropriate place for inpatient detoxification. 96.5% of service providers were in favour of developing the follow-up treatment services for alcohol and

drugs. Addiction counsellors jointly appointed between detoxification services and current community based drug and alcohol treatment services emerged as the most favoured option for development of services post-detoxification.

Conclusions: Demand for drug and alcohol treatment services is rising in Cork and Kerry. Current best practice according to international models of care is that primary care should be the main setting for detoxification with specialist care used selectively. GPs in Cork and Kerry recognise this and are willing to take a central role in detoxification given adequate support.

Recommendations: Primary care to become the main setting for detoxification, designation of beds in psychiatric/medical services for detoxification, development of specialised services for detoxification including multidisciplinary teams and specialists for alcohol/substance misuse and a Substance Misuse Detoxification Team. Link counsellors should be employed. These should work between the community based specialist addiction counselling services and all services which currently provide detoxification (i.e. A&E, GP, Medical wards). Level-2 methadone trained GPs should be facilitated so that opiate users can be commenced on methadone in the region. A national strategy for drug and alcohol services should be developed.

GLOSSARY OF TYPES OF TREATMENT FOR ALCOHOL AND DRUG MISUSE

The following is a summary of some of the treatment types that are available for alcohol and drug misuse.

Detoxification Programmes

The aim of detoxification is to eliminate opiates or other drugs from the body. Detoxification is carried out for a number of drugs, particularly alcohol and opiates. Detoxification usually involves the use of a substitute longer acting medication than the drug of abuse. It is conducted by gradually reducing the dosage until the individual is drug free. In some instances detoxification is undertaken without the use of substitute medication. Detoxification may take place in a community or hospital setting. A detoxification service is sometimes offered in voluntary treatment centres (e.g. Cuain Mhuire in Bruree offer an in-patient detoxification service).

In-Patient Treatment Services

In-patient services generally provide detoxification and early rehabilitation, on a short-term basis (days to weeks). In Ireland, in-patient treatment services for alcohol and drugs are usually provided in general psychiatric units. There are some specialist detoxification units who deal exclusively with detoxification and early rehabilitation in the Eastern Region. On completion a number of patients will go on to residential rehabilitation services.

Residential Services

Residential services provide a managed environment for drug users who are trying to become drug-free. Internationally, residential treatment programmes are usually divided into three broad categories.

1. Therapeutic Communities, where residents attend intense therapy sessions.
2. Twelve step models based on Alcoholics/Narcotics Anonymous. The

approach is based on spiritual as well as practical guidance. The aim is for long-term abstinence.

3. More general houses, some of which have a religious based philosophy. The approach used is based on group and individual therapy.

Minnesota Model of Treatment

The Minnesota Model of treatment is used in some residential services for the treatment of those with alcohol and drug problems. It refers to a combination of treatments including individual and group counselling, relapse prevention groups addiction education and post-treatment planning. It is based on the twelve steps model.

Counselling

Counselling plays an important role in the drug and alcohol treatment therapy and can include psychological therapy and group therapy. It can also include practical advice on issues such as health problems, criminal justice problems, housing and social problems.

Self-Help Networks

Narcotics Anonymous and Alcoholics Anonymous are international self-help organisations. They provide local support groups for those with alcohol problems and other problems with other drugs of addiction.

Methadone Reduction Programmes

In some instances methadone is prescribed over the medium term in gradually reducing doses. The aim is to reduce withdrawal symptoms while coming off opiate drugs. The time in which abstinence is reached varies widely from individual to individual from weeks to months.

Methadone Maintenance Programmes

The aim of methadone maintenance is to stabilise the user by prescribing a substitute for heroin and other opiate drugs. Methadone is the most commonly used substitute for those treating opiate addiction. It is also the most evaluated form of treatment. International evidence surrounding methadone maintenance indicates that methadone significantly reduces heroin use, drug related crime and the spread of drug-related diseases through injecting drug use.

Needle/Syringe Exchange Schemes

Needle/syringe exchange schemes provide injectors with clean injecting equipment to prevent them from using needles more than once or sharing with other people. They also facilitate the safe disposal of equipment which otherwise constitutes a potential health hazard.

Some argue that these schemes encourage injecting use of opiates. However, research indicates that there are lower HIV rates among injecting drug users, where there are good exchange facilities available. Needle/syringe facilities are now recognised internationally as a central part of a harm reduction strategy.

CHAPTER ONE INTRODUCTION

1.1 INTRODUCTION

The introductory chapter sets the scene for this needs assessment on drug and alcohol detoxification services in the Health Service Executive-South (formerly Southern Health Board SHB). Reference is made to the cost of alcohol and drug related problems in Ireland and the current national strategies for these issues. The background to the local needs assessment is outlined.

1.2 ALCOHOL IN IRELAND

The Irish Government unveiled its National Alcohol Policy in 1996 in an effort to tackle the growth of alcohol abuse and alcohol-related harm. During the period 1989 to 2001, Ireland has had the highest increase in alcohol consumption in EU countries. The societal costs of this are enormous:

(A) Alcohol related mortality has increased in Ireland over the last decade.

Over the period 1992-2002, 14,223 people died in Ireland from five conditions related to alcohol consumption (cancers related to alcohol, alcohol chronic conditions e.g. alcohol dependency, chronic liver disease and cirrhosis, acute alcohol conditions and suicide associated with alcohol consumption)[1].

(B) The costs associated with alcohol related injuries are high in human and financial terms:

- (i) In 2002, alcoholic disorder was the second highest cause for admission to psychiatric hospitals, after depressive disorders, for males and the fourth highest for women[2].
- (ii) It is estimated by the National Safety Council that alcohol is involved in 40% of road deaths and at least 30% of all road accidents each year in Ireland[3].
- (iii) An update of the estimated economic costs of alcohol related problems on Irish society was 2.65 billion euro in 2003[4].

1.2.1 National and European Policy in relation to Alcohol

Ireland endorsed the European Charter on Alcohol. The Charter obliges each government to develop a national policy on alcohol and lists ten areas of health promotion that need to be addressed for reduced alcohol-related harm. Included is the need to ensure that effective treatment services are available for those who are affected by alcohol.

1.2.2 Alcohol in Cork and Kerry

Treatment demand for problem alcohol use in Cork and Kerry for the years 2000 to 2002 has been reviewed using the National Drug Treatment Reporting System Reporting System (NDTRS) [5]. This review shows that in 2002, of all the clients presenting to the treatment services, the main problem substance was alcohol in 64% of cases.

In 1996, a survey of smoking, alcohol and drug use in the Cork and Kerry [6] found that almost one quarter of men drank in excess of the recommended guidelines of 21 units per week. As estimated by the CAGE screening test almost one in ten had problem/dependent drinking. This rose to 13% for those in the 20 to 24 year age group. This survey was repeated in 2004. Results showed that 22% of men and 11% of women showed problem/dependent drinking.

1.3 DRUGS OTHER THAN ALCOHOL

1.3.1 The Societal Cost of Drug Use other than Alcohol

The costs of drug misuse particularly include costs to the individual and society as a whole. Costs to the individual include harming mental and physical health including an increased risk of blood borne viruses[8].

Costs to society include:

- (i) Undermining family life – compromising the health and development of children.
- (ii) Committing of offences, particularly acquisitive crime and so harming

individuals and businesses.

- (iii) Damaging neighbourhoods – including intimidation by drug dealers and discarded needles[9].

1.3.2 National Policy in relation to Drugs other than Alcohol

Ireland's national drug strategy[10] identifies heroin misuse as having the greatest impact, for the reasons outlined above, in terms of the amount of harm to society and the individual. The strategy acknowledged that opiate misuse was primarily a problem in the area of the Eastern Regional Health Authority (ERHA). It also identifies the most commonly used illegal drug as cannabis followed by ecstasy.

The strategy sets out objectives in relation to treatment such as having in place a range of treatment and rehabilitation options for each drug misuser and developing comprehensive residential treatment models incorporating detoxification and high quality rehabilitation.

1.3.3 Impact within the HSE-South

A recent review [5] of trends in treated opiate use between 1998 and 2002 shows that, there was a four-fold increase in treated opiate use in the seven health board areas outside the ERHA.

The average annual incidence of treatment for an opiate as a main problem drug among persons aged 15 to 64 years by county of residence was 5 cases per 100,000 of the population in Cork and one case per 100,000 of the population in Kerry. These were low compared to the highest incidence in counties in Carlow of 21.2 per 100,000 of the population.

The Southern Health Board survey of drug use in 1996 [6] found a lifetime use of 18% for drugs other than alcohol. The drugs used were cannabis, hallucinogens and stimulants. Heroin use was scarcely detected in this survey and there was almost no injecting drug use.

When this survey was repeated in 2004, the percentage of people who had ever

used a drug had almost doubled to 34%. 2% had ever taken opiates.

1.4 TREATMENT SERVICES FOR ALCOHOL AND DRUG PROBLEMS

Treatment services alone will never provide an effective response to alcohol or drug dependence. Treatment services are only one aspect of a multi-faceted approach to combating alcohol and drug related problems in our society. National policies aim to prevent alcohol and drug misuse to help people avoid health-damaging behaviour. Nevertheless, treatment services are essential.

In the provision of treatment services, the role of detoxification is important. Detoxification is sometimes lifesaving. It should also provide an opportunity to link into longer-term treatment services, thus leading to reduced alcohol and drug-related harm and abstinence in some instances.

The HSE-S strategy for the development of mental health services 'Focussing Minds' [11], says that dedicated detoxification services and protocols for detoxification in the region need to be developed.

1.5 STUDY BACKGROUND

The Drug and Alcohol Committee of the Southern Health Board (HSE-S) requested that a needs assessment of detoxification services be undertaken in the region. Following initial investigation, the task identified was to review the appropriate settings and the need for detoxification for alcohol in the area. The need for opiate detoxification was also to be reviewed. Another task was to explore how detoxification might link as seamlessly as possible into follow-up treatment services.

The Drug and Alcohol Co-ordinator for the Southern Health Board funded the project. The author, with the help of support staff from the Department of Public Health, HSE-South, led and completed the project.

This needs assessment focuses on the needs of the general adult population in relation to drug and alcohol detoxification. It focuses primarily on the needs for alcohol and opiate detoxification. It has not reviewed the need for detoxification

services for children under the age of 18 years or need for detoxification in prisons.

Because the fieldwork for this study was completed in 2003: questionnaires, interview guides etc. refer to the Southern Health Board (SHB). In January 2005, due to the establishment of the Health Services Executive, the former SHB area is now referred to as HSE-South (HSE - S) of Cork and Kerry. The term HSE - S and SHB will be used interchangeably in this report. In the main, issues, which pertain to the period prior to January 2005, will refer to SHB.

CHAPTER TWO AIM AND OBJECTIVES

2.1 AIM

The aim of this study was to estimate the need for alcohol and drug detoxification services within Cork and Kerry.

2.2 OBJECTIVES

The objectives of the study were as follows:

1. To review the background research relating to the prevalence of alcohol and drug misuse in Cork and Kerry.
2. To examine the following issues by reviewing the relevant literature.
 - a. Different models of alcohol and drug detoxification internationally.
 - b. The indications and thresholds for alcohol and drug detoxification.
 - c. The different settings (primary, secondary or tertiary) for alcohol and drug detoxification.
 - d. Improving linkages between detoxification and other post - detoxification treatment services.
3. To describe the current alcohol and drug detoxification services in the Health Board region.
4. To obtain the views of clients on the current detoxification services.
5. To consult with current service providers on their views of the current and future need for alcohol and drug detoxification services.
6. To make recommendations based on the need for alcohol and drug detoxification in Cork and Kerry based on the research findings.

CHAPTER THREE LITERATURE REVIEW

3.1 SUMMARY OF THE LITERATURE REVIEW

This review of the literature provides a review of health needs assessment and particular issues in relation to health needs assessment for alcohol and drug misuse. It also provides an overview of treatments for alcohol and drug misuse, their effectiveness and cost-effectiveness. Detoxification is one option for treatment but is closely linked with other treatment options and, therefore, cannot be considered in isolation.

Detoxification for alcohol is effective and cost-effective particularly if carried out in the community[12]. Detoxification from opiates using methadone is usually one part of a spectrum of treatment, which offers longer-term methadone maintenance also. Overall, there is evidence that methadone treatment is cost-effective.

The process of detoxification is reviewed. Current guidelines and evidence of treatments used for alcohol and drug detoxification are summarised. Chlordiazepoxide is the drug of choice for alcohol withdrawal and methadone is the commonest drug used for opiate withdrawal in Ireland and the UK.

The settings for both alcohol and drug detoxification are considered. The majority of detoxification for both can be carried out in the community setting, but there is a need for a small number of specialist in-patient beds for more complex cases.

Finally, models of care for alcohol and drug misuse are considered, including *Models of Care* from the National Treatment Agency in the UK[13] and the recent report from the Irish College of Psychiatrists[14]. These emphasise the importance of having different treatment tiers so that the patient is treated at the most appropriate level and can move between levels as the need arises. The model also includes integrated care pathways and care planning for individual clients to ensure a seamless service.

Cook's[15] model of care for an integrated approach to alcohol treatment is also discussed. This model has a SMIT (Substance Misuse Integration Team) or CAT (Community Alcohol Team) with a consultant and support staff, their purpose being to assist detoxification for GPs in the community and provide specialist cover for a small number of inpatient detoxification beds.

3.2 INTRODUCTION

Although the focus of this study is detoxification, detoxification for alcohol and drugs is closely linked with other treatment modalities. Therefore, other treatments for alcohol and drug misuse including their effectiveness and cost-effectiveness are discussed in this literature review.

The literature is reviewed under the following headings:

- a. Health needs assessment.
- b. Alcohol misuse.
- c. Treatment of alcohol misuse, effectiveness and cost-effectiveness of treatment for alcohol misuse.
- d. Detoxification, definition, process and goals.
- e. Acute Alcohol Withdrawal.
- f. Settings for alcohol detoxification.
- g. Models of care for alcohol treatment services.
- h. Detoxification Centres for Homeless People.
- i. Drug Misuse.
- j. Treatment of drug misuse.
- k. Effectiveness and cost-effectiveness of treatment for drug misuse.
- l. Detoxification from drugs other than alcohol.
- m. Models of care for treatment of adult drug misusers.

Irish literature is used where available. A considerable proportion of the research papers/reports/documents informing this literature review were published in the United Kingdom (UK). Ireland has high levels of alcohol consumption compared with other European countries and is similar to the UK in that respect. For example, the average volume of alcohol consumption reported by respondents in Ireland (expressed in pure alcohol aged 18 years and over) amounts to 9.3

litres[16]. In the UK it is 9 litres compared with 3.5 in Sweden. The UK is also the closest country to Ireland geographically. For these reasons, literature from the UK was considered particularly appropriate for review in the context of service development for detoxification in Ireland.

3.3 HEALTH NEEDS ASSESSMENT

3.3.1 Definition of Health Needs Assessment

Health needs assessment is defined in the Oxford Handbook of Public Health Practice [17] as a 'systematic method of identifying unmet health and healthcare needs of the population and making changes to meet these unmet needs'. The overall aim of the health care needs assessment is to provide information to plan, negotiate and change services for the better and to improve health in other ways.

Many would consider the book edited by Stevens and Raftery [18] as the seminal work in health care needs assessment. In this needs assessment Stevens and Raftery's book was used extensively as a reference guide.

3.3.2 Needs Assessment for Alcohol Misuse

In Stevens and Raftery's book, Cook[19] outlines the main arguments in relation to needs assessment for alcohol misuse. These are:

- a. Services should be planned with the maximum of integration between agencies and between different levels of care, preferably with a community alcohol team or substance misuse integration team playing a key integrative and facilitatory role.
- b. Service improvement should seek to improve the use, and training, of staff in existing service settings rather than invent new ad hoc arrangements.
- c. Primary care and generalist care should be the main settings for treatments, with specialist care skill necessary on occasions, but deployed selectively.

3.3.3 Needs Assessment for Drug Misuse

Marsden[20] outlines the approach to needs assessment in the chapter on drug misuse in Steven's and Raftery's book. There is a need to provide detoxification in the community by 'specialist community prescribing' services, which provide opioid detoxification and substitution treatment. There is also a need to provide a numerically small but important element of treatment provision in specialist inpatient units.

In addition to dealing with opioids, community-prescribing services deal with dependent use of other drugs by their clients. Many other illicit drugs do not require prescription or use of a similar drug for detoxification e.g. cannabis, solvents, ecstasy. With these drugs, all that is required for detoxification is supportive care.

Benzodiazepine abuse usually requires a gradual reduction in dosage.

3.4 ALCOHOL MISUSE

3.4.1 Definition of alcohol misuse

Alcohol misuse may be defined 'as the personal use of alcohol such as to threaten or damage the health or social adjustment of the user or those other persons directly affected by his or her drinking'[15].

3.4.2 Sub - categories of Alcohol Misuse

For the purposes of needs assessment Cook [15] outlines a three point classification of alcohol misuse:

- a. Category 1: Excessive drinking without problems or dependence
- b. Category 2: Excessive drinking with problems but without dependence
- c. Category 3: Excessive drinking with the occurrence of both problems and dependence.

These categories are not considered to be independent of each other but are strongly inter-related. They are also useful for service planning as different

services will be required for each category.

Category 1 comprises anyone drinking over the recommended limits (21 units of alcohol per week for men or 14 units for women). This kind of misuse falls within primary health care as a target for health education and advice but may also be picked up in general hospital settings.

Category 2 is excessive drinking with problems but without dependence. The problems may be acute (e.g. an alcohol related accident, pancreatitis from binge drinking or chronic (e.g. hypertension or cirrhosis). These problems will be dealt with partly by the primary care team but also contribute to the caseload of a general hospital. Patients in category 2 may sometimes require medical detoxification.

Category 3 is excessive drinking with problems and dependence. Patients with dependence typically present to psychiatric services or specialised non-statutory services for help with the dependence itself or because of a cluster of associated health, interpersonal or social problems. The physical complications, which such patients sustain, mean that they may also present to general hospitals. Severely dependent patients may suffer from a range of complications on withdrawal, which at the extreme can include delirium tremens and alcohol withdrawal fits. These patients require medical detoxification.

3.4.3 Other Classifications of Alcohol Misuse

3.4.3.1 Dual diagnosis

This relates to patients who have co-morbid psychiatric and substance misuse disorders. Special consideration may need to be given to alcohol or drug misusers with and without other psychiatric disorders.

3.4.3.2 Misuse of multiple substances

Separate consideration again may need to be given to the needs of polysubstance abusers as distinct from those who abuse alcohol alone.

3.4.3.3 *Other factors*

Some groups may need special consideration in needs assessment e.g. ethnic minorities, homeless or 'significant others', those seeking help because of the drinking of a spouse, relative or friend.

3.5 TREATMENT OF ALCOHOL MISUSE, EFFECTIVENESS AND COST-EFFECTIVENESS

In this section, treatment options for alcohol misuse will be considered along with evidence of their effectiveness. Cost-effectiveness of treatment of alcohol misuse will then be discussed.

Category 1 (Excessive drinking without problems or dependence)

Category 1 is treated in the community by means of brief counselling and health education.

Category 2 and 3 (Category 2: Excessive drinking with problems but without dependence. Category 3: Excessive drinking with the occurrence of both problems and dependence)

A range of interventions including detoxification, brief counselling to extended residential rehabilitation, is used to manage category 2 and 3 alcohol misuse.

3.5.1 *Counselling or Psychotherapy*

Currently, cognitive-behavioural forms of psychotherapy are popular, with motivational interviewing and relapse prevention being widely used. Counselling and psychotherapy may be offered on an individual basis or in a group setting. There is now an extensive research base to support the efficacy of motivational interviewing and cognitive behavioural psychotherapy in the treatment of alcohol misuse[21].

Chick et al [22] ~~also~~ ~~the~~ ~~efficacy~~ in terms of reduced alcohol consumption 12 months later, of ~~diagn~~ given by a nurse on a general hospital ward to patients with drinking problems .

Brief interventions are likely to be highly cost-effective in Category 2 misuse (they have not been evaluated for Category 3). The cost of the intervention is low, the cost of untreated alcohol ~~is~~ ~~thousands~~ and there is good evidence of efficacy [23]

3. 5. 2 Det o i f i c a t i o n

Previously, mortality associated with delirium tremens was about 10%, and alcohol withdrawal fits could also be life threatening. Nowadays there is a zero mortality associated with withdrawal in competent hands. With regard to cost-effectiveness, in one study costs of inpatient detoxification for mild to moderate dependence were 9-20 times greater, with difference in outcomes after 6 months of treatment [12].

However , for selected cases inpatient detoxification is essential in order to prevent serious morbidity and mortality such cases cost-effectiveness (if evaluated) would be high [15] .

3. 5. 3 12 Step programmes

Many voluntary and some statutory treatment centres operate a self-help programme based on the 12 steps. Alcoholics Anonymous (AA) operate a self-help programme also based on the 12 steps . Although there are no controlled trials on AA's effectiveness, there are ~~no~~ ~~reasons~~ believe that treatment policies, which encourage AA attendance, are likely to confer benefit. Subjects who attend AA regularly do better than those who do not, with 40-50% of those who attend achieving 40- 50% abstinence that AA is freely available to all who wish to attend, it must be cost effective with the proviso that there is research evidence of its efficacy) [15] .

3.5.4 Pharmacological Treatments

Two drugs are available to assist in the maintenance of abstinence from alcohol. Disulfiram is a deterrent drug, which produces an unpleasant interaction with alcohol. Acamprosate has an action on brain neurotransmitters and may work by reducing the craving for alcohol. Disulfiram, when accompanied by psychological support, is effective in reducing the number of drinking days and the amount drunk but does not benefit all patients[24]. Acamprosate has been shown to double the locally achieved abstinence rates following treatment in 10 out of 11 randomised controlled trials[15].

Little is known about the cost-effectiveness of disulfiram or acamprosate. Acamprosate is an expensive drug but if it is used appropriately and given its efficacy, it is still likely to be cost-effective.

3.5.5 Cost - Effectiveness and Treatment of Category 2 and 3 Alcohol Misuse

Godfrey[25] [26]has reviewed the relevant literature on cost-benefit and cost-effectiveness of alcohol treatment with the following conclusions:

- a. Failure to provide appropriate treatment for these types and degrees of alcohol misuse constitutes a policy of cost-ineffectiveness. Untreated or inappropriately treated patients make heavy and repeated demands on treatment services in an ad hoc, unplanned and often entirely unproductive fashion. One US study has suggested that the untreated alcoholic, on average, incurs 200% of the general health care costs of a non-alcoholic, with a sustained reduction in this excess after treatment[27].
- b. Whilst, in general, a primarily inpatient approach to treatment is not cost effective, in-patient care will be effective for the complicated case.

3.6 DETOXIFICATION

3.6.1 Definition of Detoxification

Detoxification provides supervised withdrawal from a drug of dependence so that the severity of withdrawal symptoms and serious medical complications are kept to a minimum[28]. Detoxification is sometimes called a distinct treatment modality but it is more appropriately considered to be a precursor of treatment because it is designed to treat the acute physiological effects of stopping drug use[29].

Therefore, detoxification should not be seen in isolation as it preferable that it is followed by longer-term treatment process. This may involve individual or group therapy or other form of rehabilitation in an inpatient or outpatient treatment service.

3.6.2 Process of Detoxification

Detoxification programmes usually involve supervision in the period immediately after cessation of drug use, when the symptoms of drug withdrawal are at their peak. It is usually a 'medicated' detoxification where a drug is administered in order to reduce the severity of withdrawal symptoms.

The drug administered usually has a longer period of action and typically is cross-tolerant to the drug of dependence (e.g. benzodiazepines for alcohol and methadone for opiates). When the initial period of the withdrawal syndrome has passed, the substitute medication is gradually reduced.

Sometimes drug withdrawal is done without the use of medication ('unmedicated' or social detoxification).

3.6.3 Goals of Detoxification

Detoxification is a process that aims to provide a safe and controlled withdrawal from a drug of dependence. In some patients it can prevent more serious life-threatening complications such as Delirium Tremens (DTs) or seizures.

Detoxification should also be a precursor to more specific drug free treatment for drug dependence. In fact, many clients do not formally enter treatment programmes for the underlying addiction at this point. Detoxification of itself is unlikely to lead to abstinence or reduced use of the abused substance in many instances.

Therefore, an important outcome of detoxification is entry into further treatment options such as counselling or rehabilitation.

3.7 ACUTE ALCOHOL WITHDRAWAL (AW)

3.7.1 Signs and Symptoms

Heavy drinkers who decrease their alcohol consumption quickly or abstain completely may experience alcohol withdrawal (AW). Not every heavy drinker will experience AW syndrome, but for most who do it is unpleasant. The symptoms of AW reflect overactivity of the autonomic nervous system. Signs and symptoms of AW can include mild to moderate tremors, irritability, anxiety or agitation. The most severe manifestations of withdrawal include delirium tremens, seizures and hallucinations.[30]

The signs and symptoms of AW typically appear between 6 and 48 hours after heavy alcohol consumption decreases. Initial symptoms may include headache, sweating, tremor, anxiety, agitation, nausea and vomiting, disorientation and in more serious cases, transient hallucinations. The initial symptoms of AW intensify and then diminish over 24 to 48 hours.[31] Convulsions may occur during acute AW. The risk of seizures increases with duration of alcohol abuse. [32]

Some researchers have suggested that the severity of withdrawal symptoms increases after repeated withdrawal episodes.[33]

Delirium tremens (DTs) is the most intense and serious syndrome associated with AW. It is characterised by severe tremor, agitation, persistent hallucinations, disorientation and large increases in heart rate, breathing rate and blood

pressure. DTs occur in approximately 5% of patients undergoing alcohol withdrawal and usually appear 3 to 5 days after the patient's last use of alcohol, and last for 2 to 3 days.[34] The overall death rate from delirium tremens is estimated at 2-10%, with death usually due to cardiovascular, metabolic or infectious complications.[32]

3.7.2 Wernicke's Encephalopathy/Korsakov's Psychosis

It is estimated that 60% of those with severe alcohol problems are vitamin deficient[35]. Thiamine deficiency occurs in those who have been abusing alcohol over long periods. Wernicke's and Korsakoff's syndromes probably represent the acute and chronic stages of the same pathological process. The symptoms of Wernicke's encephalopathy include confusion, blurred vision, unsteady gait or ataxia, external ocular palsies and un-co-ordinated eye movements[36].

Whilst Wernicke's encephalopathy is treatable and the symptoms are reversible, subsequent progression to Korsakov's psychosis is a potential long-term problem if thiamine deficiency remains untreated.

3.7.3 Measurement of Severity

Objective quantitative scales have been developed to measure the severity of AW. The most common of these [37] is the Clinical Institute Withdrawal Assessment for Alcohol scale (revised). This is a ten-point scale based on objective physiological and behavioural measurements as well as relevant symptoms. A higher total score reflects a higher risk of major withdrawal symptoms such as DTs or seizures.

Gross et al [38] in a comparison of different rating scales for the alcohol-withdrawal syndrome concluded that the different rating scales will need to be subjected to trials designed solely to assess their reliability and their validity on a number of subjects.

3.7.4 Clinical Management of Alcohol Withdrawal

3.7.4.1 General Management

Patients undergoing AW often need adjunctive treatment for a variety of medical conditions[39]. For example, treatment may be required for cardiac conditions, liver disease or infections and vitamin deficiency states.

3.7.4.2 Management of AW with Medication

In a review of the medication management of alcohol withdrawal, Mayo-Smith found that benzodiazepines were suitable agents for alcohol withdrawal, with the choice between different agents guided by the duration of action, rapidity of action and cost. [40] In the guidelines produced by the Department of Health UK, the drug of choice recommended for alcohol withdrawal was chlordiazepoxide (Librium) 10 mg. [41] The following regime was recommended:

Day 1 & 2	20-30mg chlordiazepoxide qds
Day 3 & 4	15mg chlordiazepoxide qds
Day 5	10 mg chlordiazepoxide qds
Day 6	10 mg chlordiazepoxide bd
Day 7	10 mg chlordiazepoxide nocte

In a clinical review, Ashworth and Gerada[42] also recommended the use of a benzodiazepines to prevent AW, stating that the most commonly used benzodiazepine is chlordiazepoxide at a starting dose of 10 mg qds and reducing over seven days.

Raistrick [43] also recommended the use of chlordiazepoxide as a first line drug of choice in detoxification. He pointed out that chlormethiazole has sometimes been associated with death due to respiratory problems in those who combine it with alcohol.

In the UK guidelines, [41] it was noted that it was useful to prescribe oral vitamin B complex or vitamin B1 50 mg twice daily for three weeks to help the recovery of thiamine levels. For those with severe deficiency states, Wernicke's

encephalopathy and Korsakoff's psychosis intravenous or intramuscular administration of thiamine may be necessary.

3.7.4.3 Symptom - triggered Therapy

An alternative to giving a fixed dose schedule of medication is symptom-triggered therapy. In this approach the patient is monitored by means of a structured clinical assessment scale such as CIWA-Ar and given medication only when symptoms cross a threshold of severity.

Two prospective randomised controlled trials [30, 44] have demonstrated that this approach was as effective in controlling symptoms as a fixed dose schedule but resulted in the administration of significantly less medication and a significantly shorter duration of treatment.

3.7.4.4 Management of AW without Medication

While the majority of clinicians agree that severe AW requires pharmacological management, the approach to treatment of mild to moderate AW is not as clear. There are few reports [45, 46] of non-drug treatment of AW.

These studies suggest that a number of patients with mild withdrawal symptoms may benefit from supportive care alone. Supportive care consists of providing patients with a quiet environment, reducing sensory stimuli as well as nutrition, hydration and reassurance.

3.8 SETTINGS FOR ALCOHOL DETOXIFICATION

Detoxification for patients for alcohol may take place in the community or in a hospital or other in-patient setting.

3.8.1 Outpatient Detoxification

Outpatient detoxification is appropriate for patients with mild to moderate withdrawal symptoms, who have no significant co-morbid conditions (e.g. psychosis or acute medical condition such as pneumonia) and have a support

person willing to monitor their progress. [47]

A prospective randomised trial [12] in Philadelphia (n=174) compared the effectiveness and costs of inpatient and outpatient detoxification of patients with mild to moderate alcohol withdrawal syndrome. There were no serious medical complications in either group. Outcome evaluations completed at one month and six months showed no differences between the groups at six months while the costs were substantially lower for outpatient treatment.

In a literature review, Fleeman [48] concludes that home detoxification is safe and clinically effective for the vast majority of problem drinkers. It is also cost-effective. However, there will always be some problem drinkers for whom home detoxification is not a viable alternative.

3.8.2 Inpatient Detoxification

Detoxification is increasingly undertaken in the community but inpatient detoxification is recommended for those at risk of suicide, lacking social support or giving a history of severe withdrawal reactions including fits and delirium tremens [42]. Patients who have co-existing acute medical illness or those who have a dual diagnosis with a psychiatric disorder may also often require inpatient detoxification[13].

3.9 MODELS OF CARE FOR ALCOHOL TREATMENT SERVICES

3.9.1 Introduction

There are a number of strategic options when choosing to develop services for alcohol misuse.[19]These include:

- a. Integration with drugs services or separate purchasing of alcohol services.
- b. Enhancement of effectiveness of existing services.
- c. High-volume/low-intensity service provision (e.g. prioritising community detoxification).
- d. Low-volume/high-intensity service provision (e.g. prioritising specialist in-patient detoxification).

- e. A comprehensive approach (e.g. which takes account of need for a variety of settings for detoxification including community and the need for a small number of specialist beds).

A comprehensive approach is the preferred option for the development of services.

3.9.1.1 *Cook's Model of Care for Alcohol Treatment*

Cook [15] outlines an integrated and prioritised community response to alcohol misuse in the chapter on needs assessment for alcohol misuse in Steven's and Raftery's book . This is shown in Appendix 1. This outlines the staff and structures required for a population of 500,000. Among the priorities outlined is the development of a CAT (Community Alcohol Team) or SMIT (Substance Misuse Integration Team). This consists of a multidisciplinary team with a full-time consultant, half-time Specialist Registrar, full-time Senior House Officer and an eight person multi-disciplinary team.

The functions of the team would include assistance with detoxification in the community for GPs and also the direct provision of detoxification in hospital for dealing with psychiatric co-morbidity and detoxification of severely dependent patients who cannot be managed as an out-patient. Access to 8 to 10 hospital beds is recommended for this population.

3.9.1.2 *National Treatment Agency (UK) - Models of Care for Drug and Alcohol Treatment Services*

The National Treatment Agency in the UK is currently developing a *Models of Care* framework for alcohol. It has already developed a framework that is primarily intended for drug treatment services[13] but which has applicability to alcohol treatment services. The model for the treatment of drug misuse is discussed in a later section.

However, a recent needs assessment for alcohol services in London[49] suggested a modification of the drug misuse model for alcohol services. The model describes four tiers of treatment, which is essentially a stepped care

approach. People should be helped at the lowest appropriate level of intervention but should be able to move through the services to higher levels of care as need dictates. Table 3.1 shows the different proposed levels of care moving from services in non-specialist settings in tier 1 to specialist in-patient settings in tier 4.

Table 3.1 Four treatment tiers suggested in Barnet alcohol needs assessment

<i>Tier 1</i>	<i>Tier 2</i>	<i>Tier 3</i>	<i>Tier 4</i>
Services In Non-Specialist Settings	Low Threshold Specialist Services For Problem Drinkers And Their Families Or Carers	Specialist Alcohol Screening Assessment and interventions	Specialist In-patient Residential and Recovery Services
Identification assessment	Drop-in services	Specialist Alcohol Screening and Assessment in the Criminal Justice System	Residential rehabilitation and in-patient detoxification
Education in alcohol related harms		Community Detoxification	Wet services
Opportunistic Brief Interventions	Opportunistic Brief interventions	Specialist Brief interventions	Floating support
Motivational interviewing	Motivational interviewing	Motivational Interviewing	Assertive outreach
Harm Reduction Approaches		Structured specialist counselling	Supported Tenancies
		Liaison services	Liaison Services
		Aftercare	Aftercare
		Controlled drinking Interventions	Controlled drinking Interventions
			Structured day programmes

Source: Barnet Alcohol Needs Assessment[49]

Community detoxification is located in tier 3 and in-patient detoxification in tier 4 in this model. It differs from the models of care for drug misusers in that there is

more emphasis placed on brief interventions. As there is good evidence for brief interventions [23] in alcohol misuse, they are an important part of alcohol service provision.

3.9.2 Combined or Separate Alcohol and Drug Services

A case can be made for or against integrating drug and alcohol services including detoxification services.

The case in favour includes the fact that the clinical and scientific approach to treatment is very similar and many clients engage in polydrug abuse and it is somewhat artificial to separate alcohol out for separate attention. A combined service arguably makes more efficient and arguably more effective use of scarce resources[50].

The potential disadvantages of combined drug and alcohol services require careful consideration particularly in the absence of research comparing the two models. One of the biggest differences is the difference in age range of those seeking treatment. The mean age of problem drinkers lies between 35 and 45 and that for drug users between 25 and 35[51]. The case against is that alcohol is a socially and legally acceptable drug. The size of the alcohol problem is far greater than the illicit drug problem. Alcohol misusers often do not consider themselves to be 'drug' users and often prefer to get help away from the 'drug' services. The more 'conventional' problem drinkers may object to the more 'deviant' lifestyles and possible criminal involvement of those who take illicit drugs.

In Ireland, drug and alcohol services are generally funded and structured separately. However, some areas such as the North-Western Health Board have a forum where stakeholders from alcohol and drug services meet regularly[52].

3.10 DETOXIFICATION TREATMENT CENTRES FOR HOMELESS PEOPLE

3.10.1 Voluntary Sector Services

In some areas special provision is made for detoxification facilities for homeless people. Raistrick [43] says that voluntary sector agencies are probably best positioned to provide specialised addiction counselling service facilities for homeless people and those with unstable social circumstances for whom accommodation is the primary need. Supported sobering up, rather than detoxification, is the principal intervention required in this circumstance.

Nurse-run detoxification facilities for homeless also exist in some areas. In a Salvation Army hostel in Bristol, there are a number of associated units. They have a preparation unit for detoxification, a unit for detoxification and a rehabilitation unit all on site[53].

3.10.2 Sobering Centres ('Drunk tanks')

Sobering centres ('drunk tanks') are areas where people who are drunk are allowed to sleep overnight and are assessed the following day for further detoxification or treatment or discharge. They have been developed, particularly in America and Australia, as a method of reducing admissions to Accident & Emergency (A&E).

There are different models of operation of sobering centres internationally e.g. many are managed by the police service, some may be run by a voluntary organisation and some others may be managed by a combination e.g. joint venture between health services and a voluntary organisation.

Many sobering centres target the homeless population. They perform more of a life safety function than a rehabilitation function[54]. Many do not access treatment services for drugs or alcohol. For safety reasons some are located in the same building as the local detoxification centre.

Staff in sobering centres vary in background; they may or may not be medically

qualified[55]. Sobering centres require strict protocols and triage systems to ensure a safe environment for clients.

3.11 DRUG MISUSE

3.11.1 Definition of Drug Misuse

The definition of drug misuse is ‘the illegal or illicit drug taking which leads to a person experiencing social, psychological or legal problems related to intoxication or regular excessive consumption and/or dependence’[56].

3.11.2 Sub - Categories of Drug Misuse

For the purposes of needs assessment, Marsden et al[20] have identified six non-independent (overlapping) population subgroups of drug users (Table 3.2).

Table 3.2 Population subgroups for drug misuse

Subgroup	Nature
A	Non-dependent drug user
B	Injecting drug user
C	Dependent drug user
D	Acutely intoxicated drug user
E	Drug user with co-morbidity
F	Drug user in withdrawal
G	Drug user in recovery

3.11.2.1 Subgroup A (non-dependent drug user)

This group comprises people experiencing drug related problems who do not meet the criteria of dependence. It may include young people who have begun to use drugs relatively recently. Because members of this group are at risk of advancing their drug involvement to more serious levels, they may be ideal candidates for early intervention.

3.11.2.2 Subgroup B (Injecting drug user)

This group comprises people who are injecting and may be at risk of acquiring and transmitting blood-borne diseases. They constitute an important group to be attracted to appropriate programmes for harm reduction and structured

treatment.

3.11.2.3 *Subgroup C (Dependent drug user)*

This group comprises people with drug-related problems who meet ICD/DSM criteria. They may need intensive community and residential treatment and aftercare support.

3.11.2.4 *Subgroup D (Acutely intoxicated drug user)*

This group is at risk because of the morbidity and mortality associated with adverse reactions and drug overdose.

3.11.2.5 *Subgroup E (Drug user with co-morbidity)*

This group consists of people who have concurrent substance-related problems and other psychiatric disorders. There is some evidence that people with substance-use disorders and co-morbid psychiatric conditions have a relatively high contact with medical services and require more intensive treatment[57].

3.11.2.6 *Subgroup F (Drug user in withdrawal)*

This group comprises people who are undergoing withdrawal following cessation of one or more classes of drug.

3.11.2.7 *Subgroup G (Drug user in recovery)*

This subgroup consists of people who have achieved recovery from their main problem drug or from all drugs. This group may require residential rehabilitation services or community-based aftercare programmes and other support.

Of these groups subgroups B to F are most likely to require detoxification particularly those in subgroup F who are undergoing withdrawal.

Other groups who require special consideration are:

3.11.2.8 Pregnant Drug Users and those with Childcare Issues

There may be reluctance on the part of pregnant drug users to present early for maternity care. This may lead to obstetric and neonatal complications.

3.11.2.9 Homeless

There is widespread recognition by service providers that the needs of homeless for drug misuse treatment and related support have not been met[58].

3.12 ESTIMATION OF NUMBER OF ILLICIT DRUG USERS

Estimating the number of illicit drug users in an area, particularly users of heroin, is notoriously difficult. This is due to the marginalized position in society that many drug users occupy and the stigmatised nature of drug use. Problem drug users are often described as a hidden population, meaning that a large proportion of the drug using population is not in contact with treatment services or included in routine statistics

3.12.1 Direct Estimation of Prevalence

In their approach to needs assessment for drug misuse, Marsden et al [20] recommend the use of direct and indirect methods to estimate the prevalence of drug use and drug related problems. Direct methods include prevalence data from direct population surveys. This includes the Psychiatric Morbidity Survey in the UK, data from homeless surveys and prisoner surveys. Indirect estimation methods include synthetic estimation methods and capture-recapture studies. Incidence data is obtained in the UK from the Drug Misuse Database.

3.12.2 Indirect Estimation of Prevalence

3.12.2.1 Capture - Recapture Method (CRM)

The Capture-Recapture Method (CRM) is becoming one of the most acceptable methods in drug use epidemiology. CRM uses the overlap between two or more (ideally independent) samples to estimate the number of the target population

not in either sample.

3.12.2.2 *Multiplier and Nomination Methods*

Other methods of estimation include the multiplier and nomination methods. An example of the use of a multiplier method is taking the annual number of people dying in a locality, applying a multiplier for drug-related mortality and assuming that these deaths represent a fraction of the drug using population[59]. In the most basic form of the nomination method, a benchmark (e.g. the total number of drug users recorded in treatment in a given year) is combined with a multiplier (e.g. a survey estimate of the proportion of the drug-using population who were in treatment in the same year) to produce a total estimate of the size of a population.

3.13 TREATMENT OF DRUG MISUSE

The range of treatments for drug misuse is considered here along with their effectiveness and cost-effectiveness. Specialist prescribing programmes including detoxification are discussed firstly followed by other treatment and harm reduction measures for the management of drug misuse.

3.13.1 Specialist Prescribing Programmes

Agonist prescribing with methadone is one of the most widely evaluated treatments for opioid dependence worldwide. There is a well-established body of research internationally and clinical evidence for substitution treatment with oral methadone. Methadone maintenance treatment (MMT) is associated with lower risks of heroin consumption, reduced levels of crime and improved social functioning[60, 61].

In a recent Cochrane Review[62], MMT was compared with other therapies e.g. Methadone Detoxification Treatments and Buprenorphine maintenance treatment. MMT was the most effective (at appropriate doses) at retaining patients in treatment and suppressing heroin use.

3.13.2 Syringe – exchange Schemes

Syringe–exchange schemes are where sterile needles and syringes are supplied for drug injecting users in order to reduce the incidence of sharing of this equipment between addicts, thus reducing the spread of blood-borne viruses. In the UK, there is evidence from observational studies that, on average, participation in exchanges is linked to a decrease in HIV-related risks for drug injectors and that contact with these services is associated with a reduction in injection risk behaviour[63].

3.13.3 Psychosocial Counselling

There are positive reports of the value of this treatment with heroin users in the prevention of relapse[64]

Of all the psychosocial counselling approaches, cognitive behavioural therapy (CBT) oriented towards prevention of relapse have received the most evaluation in other countries. In a review on CBT, Carroll concludes that there is good evidence for the effectiveness of CBT compared with no-treatment controls[65].

A recent Cochrane review compared psychosocial and pharmacological treatments versus pharmacological treatments alone for opioid detoxification[66]. The authors concluded that psychosocial treatments offered in addition to pharmacological detoxification treatments are effective in terms of completion of treatment, compliance and results at follow-up. Detoxification alone without other treatments, attenuates the severity of withdrawal symptoms and, therefore, it can at best be partially effective for a chronic relapsing disorder like opiate dependence. However, it is an essential step to drug free treatment and it is desirable to develop adjunct psychosocial approaches that might make detoxification more effective.

3.13.4 Residential Programmes

These programmes include hospital inpatient units and residential rehabilitation units. There are a relatively small number of studies in this area.

With regard to residential treatment programmes the majority of evaluations have been of the therapeutic communities (TC) programmes. The studies show on average that clients receiving TC treatment show enduring post-discharge reductions in illicit drug use[67, 68].

3.13.5 The Cost - effectiveness of Treatment for Drug Misuse

Several cost-effectiveness studies, mostly in the USA, have looked at the outcomes of treatment achieved for specific costs. This involves the estimation of whether the costs of a drug misuser's treatment are offset by reductions in expenditure in other health services or in reduced victim costs because of lower expenditure in crime. Almost all studies that have examined changes in crime (mostly robbery or property oriented crime) have shown a reduction in costs to retailers, insurers and individuals. The US Treatment Outcome Prospective Study (TOPS)[69] found that the ratio of benefits to costs was substantial in most incidences).

Basic economic analyses from the National Treatment Outcome Research Study (NTORS) in the UK have focused on the overall costs of providing treatment versus the costs due to crime within the cohort. It has been estimated for every £1 spent on treatment, there is a return of more than £3 in terms of costs savings to victims and the criminal justice system[70].

3.14 DETOXIFICATION / WITHDRAWAL FROM DRUGS OTHER THAN ALCOHOL

Detoxification in this case refers to the withdrawal over a short period from an opioid or sedative/hypnotic drug by the use of the same drug, or similar drug in decreasing doses. The process can be assisted by the temporary prescription of other drugs to reduce withdrawal symptoms.

For some people, general support, advice re symptoms and encouragement may be sufficient during the withdrawal period. For others, a lack of social support or a history of serious withdrawal complications (e.g. fits) or other issues may make substitute prescribing necessary.

3.14.1 Detoxification from Opiates

3.14.1.1 Opiate Withdrawal Syndrome

Withdrawal from opiates is associated with a specific withdrawal syndrome and symptoms and signs include sweating, lacrimation, yawning, feeling hot and cold, anorexia and abdominal cramps, diarrhoea, insomnia and restless tachycardia and hypertension [71]. There are some physical similarities between withdrawal syndromes from opiates and alcohol in that both are triggered by an overactivity of the autonomic nervous system.

3.14.1.2 Maintenance, Methadone Reduction and Methadone Maintenance

The first step in the treatment of dependence that aims at abstinence is detoxification. Detoxification eliminates opiates and other drugs from the body.

The term 'detoxification' in relation to opiate misuse is sometimes used to describe a programme in which the client is opiate-free from day one. However, methadone reduction programmes where methadone is prescribed in gradually reducing doses over a period of weeks or months are often also described as detoxification. The important point is that clients are opiate-free at the end of the programme.

Some authors have used the cut-off point of maximum of 26 weeks, detoxification or methadone reduction where methadone is prescribed for up to that length of time with the result of gaining a drug-free status [72].

Methadone maintenance occurs when methadone is prescribed on an ongoing basis to stabilise the client. Maintenance may occur for months to years [41].

Therefore, detoxification from opiates may be carried out as a sudden cessation of the opiate and subsequent management of withdrawal symptoms with or without substitute medication, or alternatively as a gradual reduction of the substitute medication over time until the individual is drug free.

3.14.1.3 *Treatment of the Withdrawal Syndrome with Substitute Opiates*

A number of drugs may be used to detoxify opiate users e.g. methadone, buprenorphine and lofexidine. Research shows that all three drugs are effective in reducing withdrawal symptoms and completion rates are satisfactory[73, 74].

3.14.1.4 *Methadone*

Methadone treatment has been used effectively and safely to treat opioid addiction for more than 30 years. Methadone is an opiate agonist and is the most frequently used agent in opiate withdrawal and maintenance in Ireland, UK and USA[75]. The medication is taken orally and it is long acting. Methadone's effects last for about 24 hours - four to six times as long as those of heroin – so people in treatment need only take it once a day.

Its slow onset of action and its long half-life blunts its euphoric effect, making it an unattractive drug of abuse.

Detoxification using methadone can be undertaken under a number of different regimes either in the short or the long term. The medication of choice recommended in the UK Guidelines is oral methadone mixture BNF 1mg/ml[41].

The European Methadone Guidelines[76] recommend an initial dose of methadone between 10 and 30mg, and that the patient be seen daily, so that a stabilisation dose of methadone can be established.

The Irish College of General Practitioners have also produced guidelines for GPs prescribing methadone in the community.

It is important that methadone treatment is not seen as an isolated intervention but as part of a comprehensive programme, which addresses medical, social, mental health and legal problems. A multidisciplinary approach to methadone treatment is essential.

3.14.1.5 *Other drugs which may be used as alternatives to methadone for opiate abuse*

Buprenorphine

Buprenorphine is a semi-synthetic opiate possessing both narcotic agonist and antagonist activity. In a report to the National Advisory Committee on Drugs in Ireland[77] the National Medicines Information Centre concluded that at doses of >8mg /day, buprenorphine was as effective as methadone as a maintenance treatment option.

Evaluation of its use in clinical practice showed that it was considered as effective as methadone for maintenance, has a better safety profile but more abuse potential. Consequently, many experts recommended supervised prescribing. Experience of its use in detoxification was more limited but was also favourable.

3.14.2 Detoxification from Benzodiazepines

3.14.2.1 *Benzodiazepine Withdrawal Syndrome*

Sudden withdrawal from benzodiazepines can lead to a recognised withdrawal state. The withdrawal syndrome associated with benzodiazepine use includes anxiety symptoms such as sweating, insomnia, headache and nausea. Disordered perceptions are also a feature e.g. feelings of unreality, abnormal sensation of movement and hypersensitivity to stimuli. Major complications such as psychosis and epileptic seizures can also occur[78].

3.14.2.2 *Management of Benzodiazepine Withdrawal Syndrome*

The Department of Health and Children produced guidelines on good practice in relation to benzodiazepines[79]. They suggest a number of methods for benzodiazepine withdrawal, the aim being to gradually reduce to zero the amount of drug being taken.

The methods include gradual reduction in dosage, substitution of a short-acting benzodiazepine for a long-acting one before attempting withdrawal or the withdrawal programme can be supplemented with concomitant therapy (i.e. other

medication which helps with the physical effects of withdrawal).

3.15 SETTINGS FOR DETOXIFICATION FOR DRUGS OTHER THAN ALCOHOL

Detoxification for drugs other than alcohol may take place in an in-patient or outpatient setting. The criteria for in-patient detoxification are considered in Section 3.16.1.5.

The majority of detoxification/reduction regimes take place as an outpatient in the community.

The National Treatment Outcome Research Study (NTORS)[80] is the first prospective national study of treatment outcome among drug misusers in the United Kingdom. The authors found that rates of abstinence from illicit drugs increased among patients for both residential and community (methadone) programmes at five year follow up.

3.16 NATIONAL TREATMENT AGENCY UK – MODELS OF CARE FOR TREATMENT OF ADULT DRUG MISUSERS

Detoxification services need to be considered in the context of the wider spectrum of a range of treatment services.

In the UK, the National Treatment Agency for adult drug misusers [13] have developed an extensive framework for developing local systems of effective drug misuse treatment in England. The primary focus of this is adult drug treatment, but the applicability of the models for alcohol treatment is recognised. The main elements of the framework are:

- (A) Four tiers of treatment.
- (B) Integrated care pathways.
- (C) Care planning and co-ordination.
- (D) Monitoring.

3.16.1 (A) Treatment Tiers

The four treatment tiers can be summarised as follows:

Table 3.3 Four Treatment Tiers for Drug Misusers

Tier	Core Function	Severity of problemat contact
1 (Generic Services)	Primary and specialist medical care; social work; social welfare and housing support	Mild-severe
2 (Open access services)	Health problems and risk reduction; information; advice and referral; prescribing; aftercare and support	Mild-severe
3 (Structured community based services)	Structured maintenance and individualised counselling; treatment of co-morbidity	Mostly moderate-severe
4 (Specialist Residential)	Detoxification; psychosocial rehabilitation	Mostly severe

client

Source: National Treatment Agency, UK [13]

3.16.1.1 Tier 1: Generic Services

Tier 1 services work with a wide range of clients including drug and alcohol misusers but their sole purpose is not drug and alcohol treatment. The role of tier 1 services in this context includes the provision of their own services plus as a minimum, screening drug misusers and referral to local drug and alcohol treatment services in Tier 2 and 3. Tier 1 consists of a wide range of professionals (e.g. primary care, social workers, teachers, pharmacists). Such professionals need to be adequately trained and supported to work with drug and alcohol misusers.

Tier 1 professionals should have clear local guidelines on the referral of drug/alcohol misusers. Where prevalence of misuse is high, need for a specialised drug/alcohol treatment or ‘addiction’ services, professionals should provide a co-ordinated response. Liaison professionals can support Tier 1 professionals.

3.16.1.2 Tier 2: Open Access Drug and Alcohol Treatment Services

Tier 2 services provide accessible drug and alcohol specialist services for a wide range of drug and alcohol misusers referred from a variety of sources including self-referral.

The aim of tier 2 is to engage drug and alcohol misusers in drug treatment and reduce drug-related harm. Tier 2 services do not necessarily require a high level of commitment to structured programmes or a complex or lengthy assessment process. Tier 2 services include needle exchange, drug and alcohol advice and information services

3.16.1.3 Tier 3: Structured Community-based Drug and Alcohol Treatment Services

Tier 3 services are provided solely for drug and alcohol misusers in structured programmes of care. Tier 3 structured services include psychotherapeutic interventions (e.g. cognitive behavioural therapy), motivational interventions, methadone maintenance programmes, community detoxification or day care provided either as a drug and alcohol free programme or as an adjunct to methadone treatment.

Tier 3 services require the drug and alcohol misuser to receive a comprehensive assessment and to have a care plan, which is agreed between the service provider and client.

3.16.1.4 Tier 4: Residential Services for Drug and Alcohol Misusers

Tier 4a services are aimed at individuals with a high level of presenting need. Services in this tier include: inpatient drug and alcohol detoxification or stabilisation services; drug and alcohol residential rehabilitation units; and residential drug crisis intervention centres. Tier 4b services include highly specialised and will have close links with the other tiers but they are like Tier 1 non-substance misuse specific. Examples include specialist liver units that treat complications of alcohol-related and infectious liver diseases and HIV liaison clinics.

3.16.1.5 *In-patient Detoxification*

Models of Care[56] gives the target groups for inpatient detoxification treatment as;

- a. People physically dependent on one or more classes of drug.
- b. People with physical or psychiatric complications or co-morbidity.
- c. People with history of complications during previous withdrawals e.g. seizures.
- d. People with chaotic polydrug use.
- e. Women who are pregnant.
- f. People who have failed to complete outpatient drug treatment programmes.
- g. People who are unlikely to cope with outpatient detoxification due to significant personal isolation or lack of support from family or friends.

It should be recognised that there are some clients with complex problems that would need to be excluded from the standard in-patient detoxification service.

These include people with:

- h. Serious acute psychiatric morbidity e.g. acute psychosis, requiring acute psychiatric treatment.
- i. Serious physical morbidity (e.g. life threatening physical illness).

These patients will require intensive care as an in-patient in a psychiatric unit or acute medical ward.

3.16.1.6 *Specialist Detoxification Units*

In-patient detoxification in the UK is provided in different settings including psychiatric wards and specialist in-patient detoxification units with on-site medical cover.

Less intensive care is available in other settings where detoxification is provided in in-patient settings where detoxification is provided in a nurse-led service according to pre-agreed guidelines with medical cover (GP usually) available on

call and visiting the unit a number of times a week.

3.16.2 (B) *Integrated Care Pathways (ICPs)*

Integrated Care Pathways (ICPs) [13] describe the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. ICPs are known by various different names, including 'critical care pathways', 'treatment protocols' or 'anticipated recovery pathways'.

Models of Care advise that each drug treatment modality should have an ICP. ICPs should be agreed between and with local service providers and should be built into service agreements. Appendix 2 gives an example from Models of Care, of integrated care pathways for inpatient detoxification.

3.16.3 (C) *Care Planning and Co-ordination*

Care planning for an individual client covers a range of options from detoxification to treatment.

Good systems of care planning and care co-ordination ensure that services are client-centred. The main principle of care planning is that each client who enters a structured drug and alcohol treatment service receives a written care plan. The care worker should agree this plan with the client and subject it to regular review.

Care co-ordination includes the systematic and ongoing assessment of health and social care needs of those attending the drug and alcohol services and the identification of a named care co-ordinator who maintains contact with the client and organises care. Care planning and co-ordination help to maximise client retention and minimise 'drop out' from the drug and alcohol treatment services.

3.16.4 (D) *Monitoring*

This involves in the first instance reliable activity reporting moving towards monitoring outcomes over time.

There is a national drug treatment dataset in the UK, similar to the Irish National

Drug Treatment Reporting System (NDTRS) database.

The UK National Treatment Agency is developing an informational strategy and minimum dataset to supplement Models of Care. Consideration needs to be given to developing similar systems here.

3.17 MARS DEN'S MODEL OF TREATMENT FOR DRUG MISUSE

In the chapter on needs assessment for drug misuse in Steven's and Raftery's 'Health Care Needs Assessment, Marsden gives a framework for levels of specialist treatment service provision and staffing for drug misuse (Appendix 3) There is no nationally agreed schedule or framework for required staffing levels in the UK. The table offers a crude estimate of typical levels of provision for three types of treatment (i) specialist community prescribing services; (ii) hospital inpatient units; and (iii) residential rehabilitation programmes.

3.18 DEVELOPING ALCOHOL AND DRUG SERVICES IN IRELAND

In 2005, the Irish College of Psychiatrists have outlined their vision for the future development of services for alcohol and drugs in Ireland [14]. It recommends the development of a four-tiered model similar to that outlined above. It says that there is a need to develop specialist multidisciplinary outpatient addiction team and that this team should encompass treatment of both alcohol and illicit drug misuse.

The report also highlights the successful ICGP pilot study in which ten GP practices received training on screening, detection, brief intervention and referral [81]. It recommends the expansion of this pilot to all GP practices, supported by training in relation to the prescribing of alcohol detoxification programmes and on-site addiction counsellors.

CHAPTER FOUR METHODOLOGY

4.1 INTRODUCTION

The methods used in this needs assessment were based on Stevens and Raftery's[18] healthcare needs assessment. The study employed three strands: review of data relating to drug and alcohol abuse and review of current services in Cork and Kerry, comparison with services in other areas and seeking the views of service providers and service users. A glossary of terms is given separately.

4.2 ETHICAL APPROVAL

Ethical approval for the study was sought and obtained from the Research Ethics Committee of the Royal College of Physicians of Ireland.

4.3 REVIEW OF DATA RELATING TO DRUG AND ALCOHOL ABUSE

4.3.1 Introduction

The three key elements reviewed [18] are;

1. The assessment of incidence and prevalence of the health problem.
2. Knowledge of the baseline services.
3. The cost-effectiveness of existing interventions.

These elements are considered in turn.

4.3.2 The Assessment of Incidence and Prevalence of Drug and Alcohol problems

Incidence and mortality data were obtained in order to estimate the need for detoxification from alcohol and drugs in the region.

Data specifically reviewed included:

- a. Number of admissions to general hospitals and psychiatric hospitals with alcohol and drug related diagnoses.
- b. Numbers of clients treated for alcohol and drug misuse in the Region.
- c. Number of clients on Central Treatment List receiving

- methadone.
- d. Local and national data from lifestyle surveys on drug and alcohol use.
- e. Deaths due to alcohol and drug related causes.
- f. Mortality due to chronic liver disease and cirrhosis.
- g. Estimates of the required capacity for alcohol treatment services for detoxification using the Rush[82]model.
- h. Review of available information on indirect methods of estimation of prevalence of opiate misuse.
- i. Demography data including population projections.

Data sources used included:

- (i) Hospital In-patient Inquiry (HIPE).
- (ii) National Psychiatric Reporting System (NPRS).
- (iii) Central Treatment List.
- (iv) Central Statistics Office.
- (v) National Treated Drug Misuse Recording System (NTDRS) is examined under current service provision.

4.3.3 Current service provision Alcohol and Drug Services

Current services for alcohol and drugs provided in Cork and Kerry are described. Local directories on service provision and interviews with service providers inform this section. NDTRS data is considered in this section.

4.3.4 Cost-effectiveness of Services

The cost-effectiveness of services for drug and alcohol treatment has already been considered in the literature review Sections 3.5.5 and 3.13.5.

4.4 COMPARISON WITH DRUG AND ALCOHOL SERVICES IN OTHER AREAS

Service provision for alcohol detoxification in Cork and Kerry is compared with results of a needs assessment in the UK and with recommendations for these services in the UK. Costs are estimated for elements of the proposed UK model

related to detoxification in an Irish setting. Service provision for drug detoxification is compared with other services in Ireland.

4.5 SEEKING VIEWS OF HEALTH SERVICE PROVIDERS AND HEALTH SERVICE USERS

4.5.1 Introduction

A combination of qualitative and quantitative research methods was used to provide as wide a review as possible of the needs for detoxification services for drugs and alcohol in Cork and Kerry.

Qualitative methods included interviews with key service providers and also clients who had been through the process of detoxification. Quantitative methods included circulating questionnaires to a range of different professional service providers involved in drug and alcohol detoxification and analysing the questionnaires, which were returned.

Qualitative interviews conducted prior to quantitative fieldwork, as was done in this needs assessment, can provide an essential preliminary to the development of the questionnaires.

Qualitative methods can be used to supplement quantitative work as part of a validation process as in 'triangulation' where three or more methods are used and the results compared for convergence e.g. interviews, focus groups and questionnaire survey[83]. The use of qualitative and quantitative methods thus provided complementary information.

4.5.2 Qualitative Interviews with Service Providers

4.5.2.1 Participant Population

Prior to the commencement of the qualitative fieldwork, a list of potential participants for semi-structured interviews was compiled. The list included all GPs, psychiatrists, medical consultants who provided 'on-call' services and consultants in accident and emergency medicine. A list of specialist addiction counselling service providers was also compiled. Specialised Addiction

Counselling Service Providers work in the addiction treatment centres in the area (Arbour House, Anchor Treatment Centre, Talbot Grove and Tabor Lodge). They come from a variety of professional backgrounds including nursing and psychology. Key senior health service managers with responsibility (but no direct clinical responsibility) for drug and alcohol services in the region were also included.

4.5.2.2 Participant selection

Participants were then purposefully chosen from the list. They were chosen to represent a cross section of geographical areas within the region including urban and rural. A cross-section of professionals were also interviewed including 4 Specialised Addiction Counselling Service Providers (SACSPs), six Psychiatrists, five GPs, an A&E consultant, a medical consultant and a health service manager.

4.5.2.3 Participant Recruitment - Service Providers

18 service providers were approached individually. Each interviewee was given an information sheet and asked to complete a consent form (Appendix 4 and 5)

4.5.2.4 Interview Guide

Discussion with service providers revolved around thirteen prompts under three main headings. These included their understanding of detoxification, their experience of detoxification within their own practice setting and the ways in which the service for detoxification could be improved within their own practice setting (Appendix 6a,b,c,d.).

4.5.3 Qualitative Interviews with Service Users

4.5.3.1 Participant Population and Selection

A screening questionnaire was used to select service users (Appendix 7). A voluntary treatment centre for alcohol and drugs (Tabor Lodge) in the HSE-SA was approached to recruit clients. Six clients were obtained. The information sheets and consent forms used for clients are shown in Appendix 8 and 9.

4.5.3.2 Interview Guide Service Users

Discussion with service users was aided by 12 prompts e.g. their understanding of the term detoxification and details regarding their last detoxification. The full interview guide is attached in Appendix 10.

4.5.4 Data Handling and Analysis Qualitative Interviews

All interviews were transcribed verbatim. All transcripts were then examined, coded and analysed using QSR NVIVO qualitative software package V2. Similar concepts/codes were grouped together and a number of subcategories and categories were identified.

4.6 QUANTITATIVE STUDY OF PROFESSIONAL GROUPS

4.6.1 Study Population

Professionals with direct involvement in detoxification include Psychiatrists, Consultants in Accident and Emergency, Medical Consultants who are on 'acute call' (i.e. oversee emergency admissions on call), GPs and Specialised Addiction Counselling Service Providers. Questionnaires were sent to all service providers in these categories in the Cork/Kerry region. There were 512 service providers in total.

4.6.2 Questionnaire Development

Questionnaires were developed to carry out a needs assessment for detoxification services for alcohol and drugs in Cork and Kerry. The literature review and the qualitative interviews informed the development of the quantitative questionnaires (Appendices 11 & 12). The questionnaire was piloted on six different professionals.

4.6.3 Analysis

Data was then imported and analysed using SPSS Version 12.

CHAPTER FIVE RESULTS PART ONE:

- A. REVIEW OF DATA RELATING TO DRUG AND ALCOHOL MISUSE, CURRENT SERVICES.**
- B. COMPARISON OF DRUG AND ALCOHOL SERVICES WITH OTHER REGIONS.**

A. REVIEW OF DATA RELATING TO DRUG AND ALCOHOL MISUSE, CURRENT SERVICES

5.1 INTRODUCTION

In this chapter, mortality data is presented followed by morbidity data and population projections. Key points from local epidemiological studies are presented followed by a model using an estimate for the required capacity for alcohol treatment services. Methods of estimating the indirect prevalence of drug misuse in Ireland are considered. This is followed by a summary of current drug and alcohol treatment services in Cork and Kerry.

Comparisons are made with current services for alcohol with services in a London borough. Services for drugs are compared with other areas in Ireland. The costs of new models of services are summarised.

5.2 MORTALITY

5.2.1 Mortality due to Alcohol and Drugs in the HSE-S

Mortality due to alcohol and drug related causes in Cork and Kerry were obtained from the Central Statistics Office (CSO). Table 5.1 summarises the data for 2001 to 2003.

Table 5.1 Deaths due to alcohol abuse and drug dependence SHB 2001-2003

Year	Deaths due to Alcohol abuse (including alcoholic psychosis)			Deaths due to Drug Dependence, toxicomania		
	Male	Female	Total	Male	Female	Total
2001	7	4	11	11	6	17
2002*	6	2	8	10	7	17
2003*	3	3	6	13	8	21

Source: CSO, 2003

*2002 and 2003 data are provisional at time of writing.

5.2.2 Mortality due to Chronic Liver Disease and Cirrhosis

Mortality due to chronic liver disease and cirrhosis is used as an indirect indicator of alcohol related problems and is useful for comparisons[15]. Figure 5.1 and 5.2 show the trends in direct standardised mortality rates over a recent decade for both males and females.

Fig 5.1

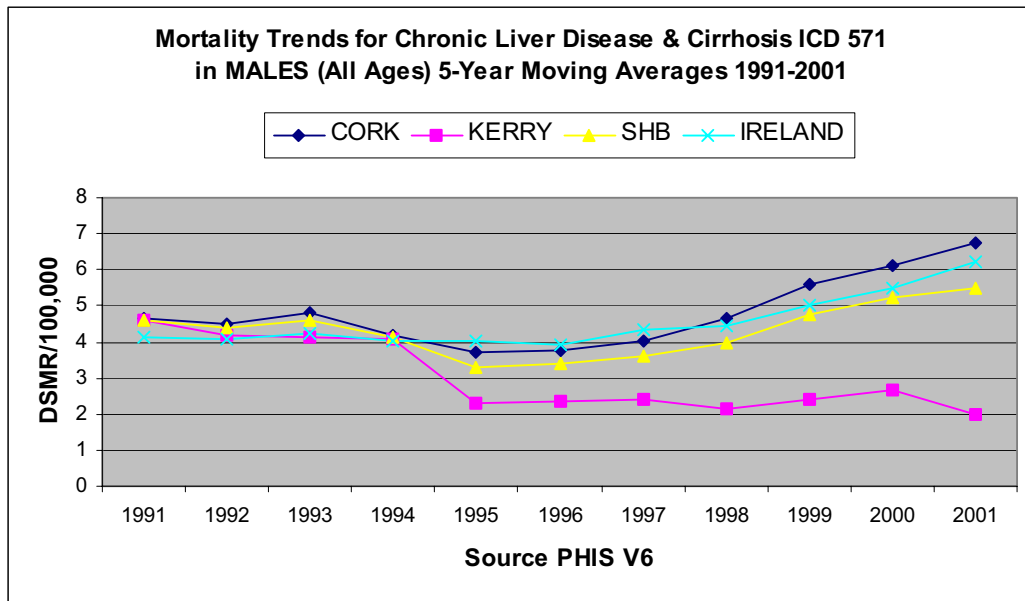
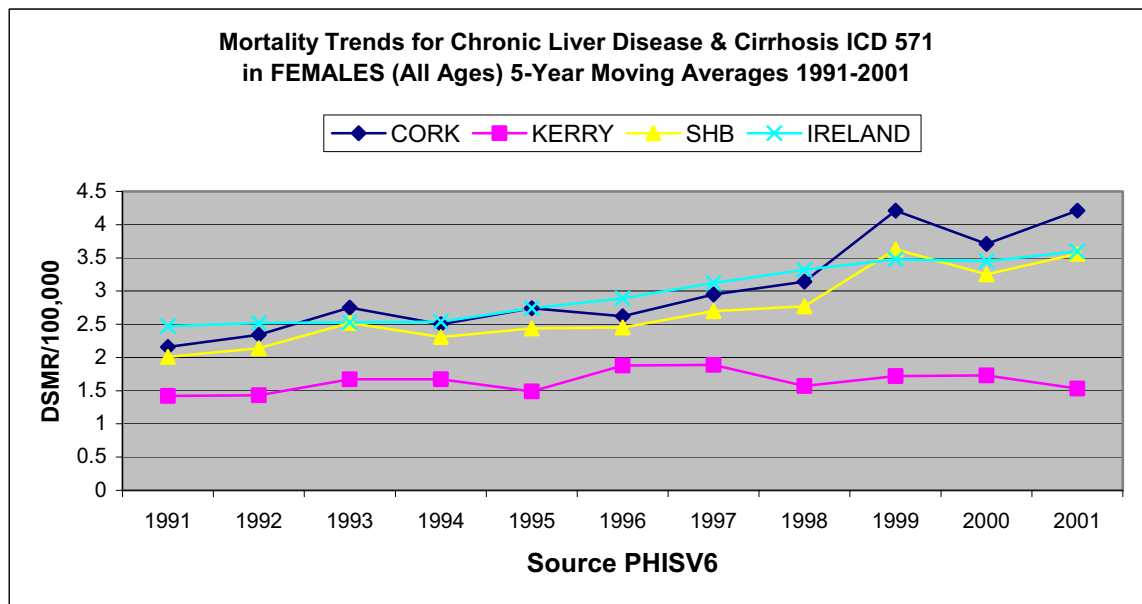


Fig 5.2



Both figures show a rising trend for Cork and for Cork and Kerry as a whole for mortality due to chronic liver disease and cirrhosis. This is in keeping with the national trends. However, the Kerry region shows a decreasing trend among

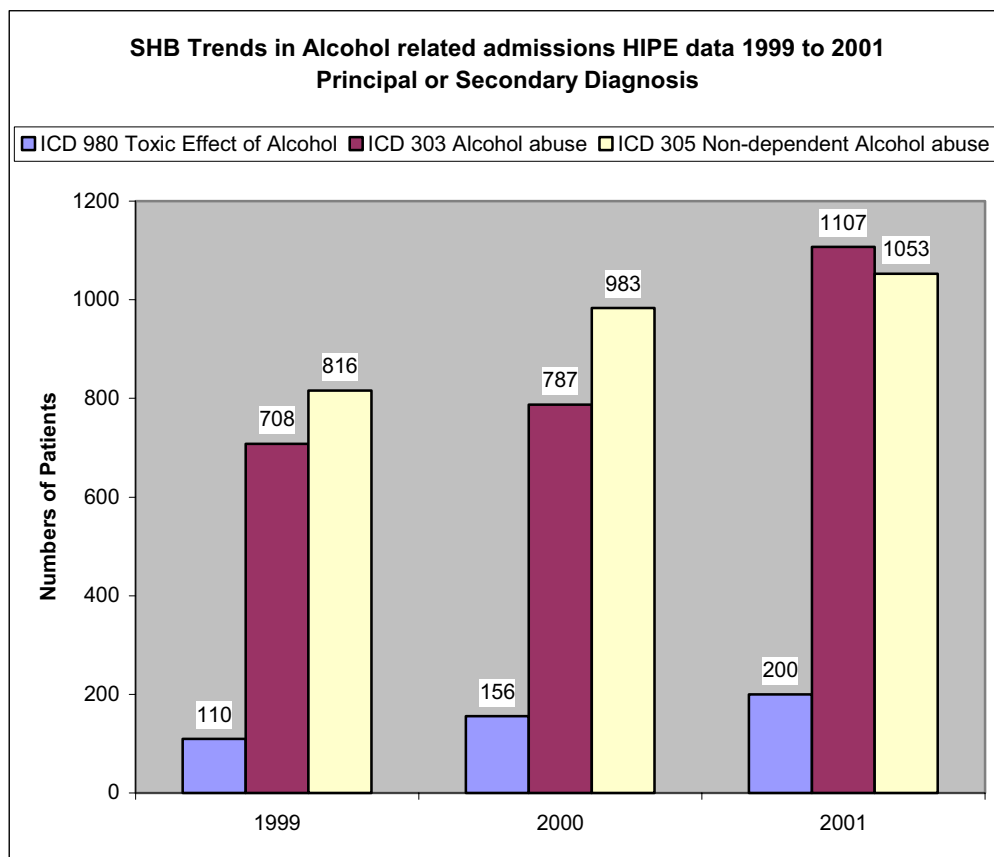
males and a flat trend among females over this period.

5.3 MORBIDITY DATA

5.3.1 HIPE Data

HIPE¹ data was reviewed for three years from 1999 to 2001. The following graph (Fig 5.3) shows the HIPE data from SHB hospitals for admissions relating to alcohol. ICD codes refer to the International Classification of Diseases (ICD-9-CM) ICD codes used are shown in Appendix 13.

Fig 5.3



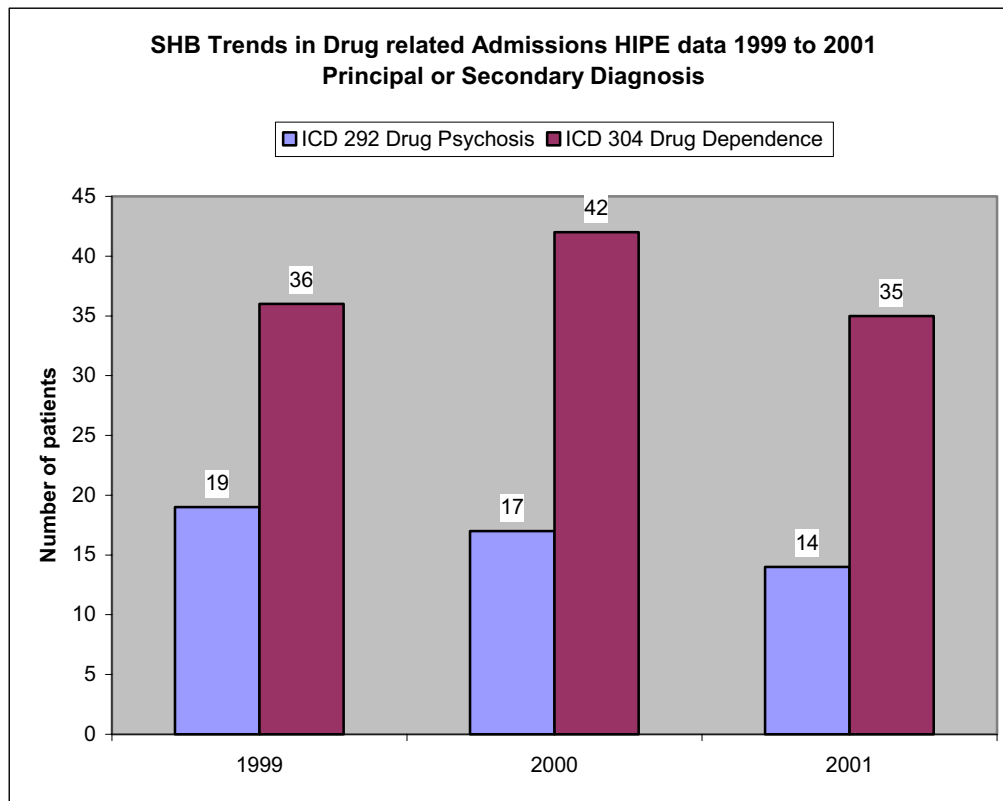
Source: HIPE, 2003

This shows an increase in alcohol related admissions between 1999 and 2001 (a 44% increase for the ICD codes included here).

¹

Fig 5.4 shows HIPE data relating to admissions to acute general hospitals in relation to drugs other than alcohol. It shows that admissions for drug psychosis and drug dependence for the period 1999 to 2001 have remained relatively low.

Fig 5.4



Source: HIPE, 2003

5.3.2 NPRS Data

Data from the National Psychiatric Recording System (NPRS) were also reviewed over a three year period. Table 5.2 and 5.3 shows the number of first admissions and the rates per 100,000 population aged 16 years and over for alcoholic disorders and drug dependence from 2000 to 2002. First admissions and rates for both conditions has remained relatively constant in this period apart from a larger number of admissions for drug dependence in 2001 compared with the other two years.

Table 5.2 SHB first admissions to psychiatric units for alcoholic disorders 2000 to 2002

	2000	2001	2002
Numbers	208	172	192
Rates per 100,000 population aged 16 years and over	51	42.1	42.6

Source: NPRS, 2003

Table 5.3 SHB first admissions to psychiatric units for drug dependence 2000 to 2002

	2000	2001	2002
Numbers	27	49	30
Rates per 100,000 population aged 16 years and over	6.6	12	6.7

Source: NPRS, 2003

5.3.3 Central Treatment List

The Central Treatment List is a national register of clients receiving methadone treatment. The Drug Treatment Centre Board manages this list. In October 1998, the Methadone Protocol was introduced making it a requirement for all clients in receipt of methadone to be on a national register. A summary report is shown of all those on the Central Treatment List in the month of July 2004. It shows the number of clients in receipt of methadone by health board area and other treatment centres including the National Treatment Centre Board and prisons.

Table 5.4 shows that the SHB had the third lowest number of clients on the Central Treatment List of all health boards in the country.

Table 5.4 Central Treatment List Summary Report for the period 01/07/04 to 31/07/04

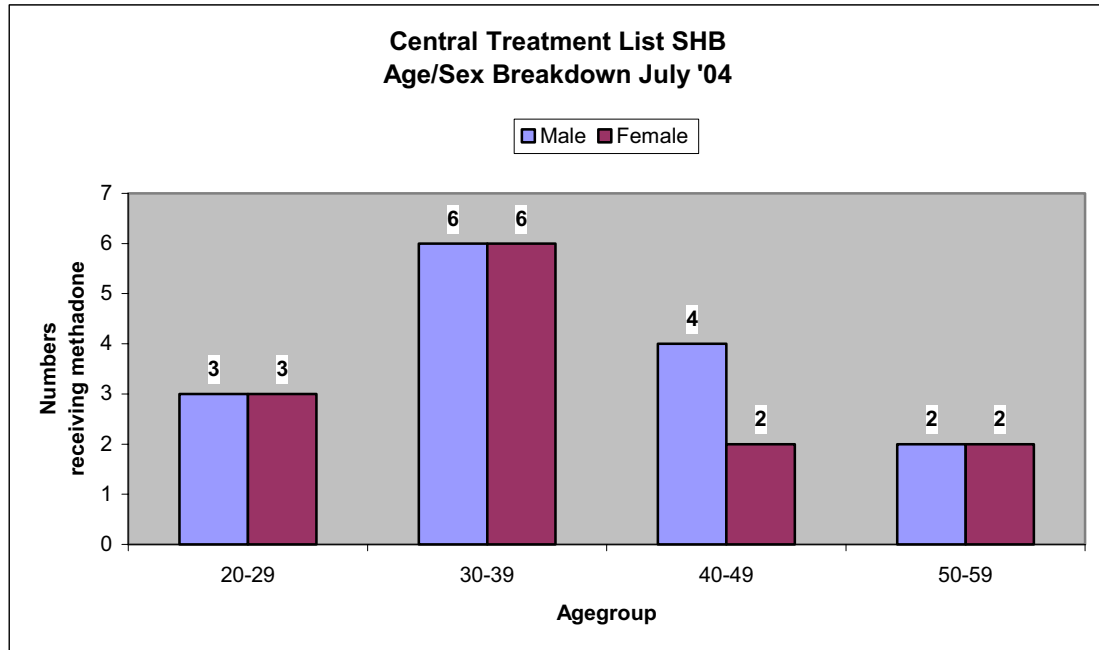
Health Board Area	Numbers of Patients Treated
South Western Area Health Board	2850
Northern Area Health Board	2496
East Coast Area Health Board	735
Drug Treatment Centre Board	533
Prisons	339
North Eastern Health Board	90
Mid Western Health Board	74
Midland Health Board	68
South Eastern Health Board	48
Southern Health Board	28
Western Health Board	26
North Western Health Board	6
Total	7292

Source CTL 2004

There were 28 clients in total on the Central Treatment Register in SHB in July '04, 15 males and 13 females.

The breakdown of clients by age and sex for this period is shown in Fig 5.5.

Fig 5.5 Central Treatment List SHB Age / Sex Breakdown July 2004



Source: CTL, 2004

There are also clients who have an address in Cork and Kerry who are receiving treatment outside the health board area. In December 2004 there were ten such people, seven were receiving treatment with a Dublin based GP, one was receiving treatment in a clinic in DunLaoghaire and the remaining two clients were in prison. This number may not reflect the total number of Cork and Kerry residents who are receiving methadone treatment in the country, as it is possible that a number of clients may be giving inaccurate addresses.

5.4 LOCAL EPIDEMIOLOGICAL SURVEYS ON THE PREVALENCE OF ALCOHOL AND DRUG MISUSE

5.4.1 Drug and Alcohol Use in Cork and Kerry 1997

The Department of Public Health carried out a survey of smoking, alcohol and drug use among 2095 adults in Cork and Kerry aged 15 to 44 years in 1996[6]. This survey was repeated in 2004[7].

5.4.1.1 Alcohol Use in Cork and Kerry

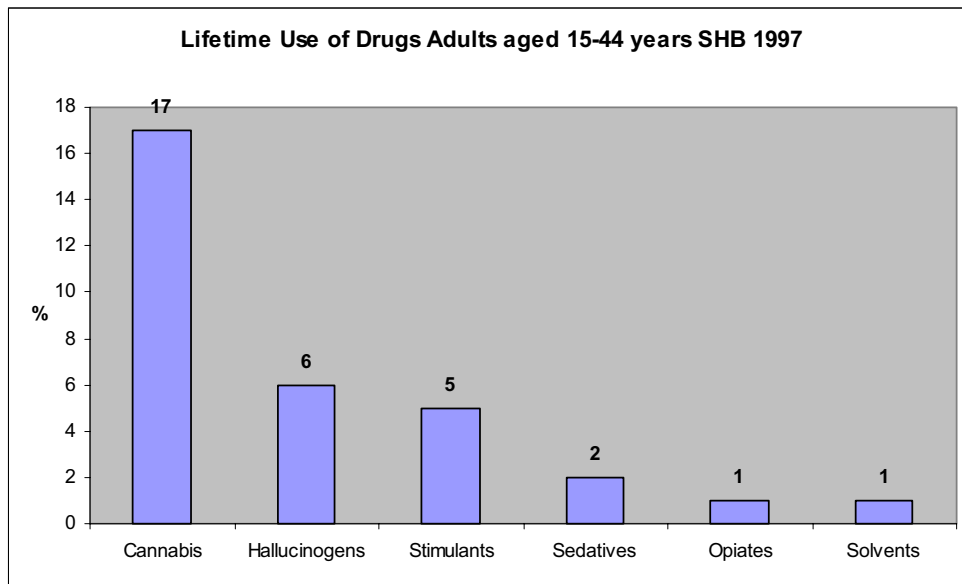
Eighty one percent of men and 75% of women were current drinkers. Twenty three per cent of men drank over the recommended weekly amount of 21 units per week. Six per cent of women drank over the recommended weekly amount for women of 14 units per week.

In 2004, there was a slight increase to 26% in the number of men who drank over 21 units per week. There was a marked increase in the number of women drinking more than 14 units per week to 26%.

5.4.1.2 Drug Use in Cork and Kerry

Fig 5.6 shows the lifetime use of drugs other than alcohol as reported in the 1996 study. Lifetime use indicates ever having used a drug in their lifetime. Eighteen per cent overall had used a drug other than alcohol in their lifetime. Cannabis had the highest lifetime use at 17%. Lifetime use for opiates was 1%. 0.6% took DF118. Only 3 (0.2%) took heroin or methadone.

Fig 5.6 Lifetime use of drugs in adults aged 15-44 year SHB 1997



Source: Department of Public Health, SHB 1997

5.4.2 SLAN Survey

The SLAN (Survey of Lifestyles, Attitudes and Nutrition) study is a cross-sectional survey of adult's aged 18 years and upwards[84]. The most recent

SLAN study was carried out in 2002. There were 2809 respondents who were regular weekly drinkers and the percentages that were drinking over the weekly limit for each health board was computed.

Table 5.5 shows the breakdown of this data. The SHB ranks in joint 6th place out of the 10 health boards at 21.3% drinking over the recommended weekly limits.

Table 5.5 Percentage of respondents who are regular weekly drinkers and over the recommended weekly limit for alcohol consumption by Health Board and gender.

Health Board	Males %	Females %	Overall %	Valid n
North-Eastern	35.9	16.9	27.4	250
Midland	27.8	11.2	21.3	252
South-Eastern	18.8	13.7	16.4	282
Southern	24.3	17.5	21.3	378
Mid-Western	21.8	19.9	21.3	218
Western	27.9	12.2	18.8	217
North Western	22.9	21.9	23.8	163
South West Area	28.1	20.7	24.4	368
East Coast Area	30.5	21.6	25.3	359
Northern Area	35.4	24.4	29.5	322

Source: SLAN, 2002

5.5 POPULATION PROJECTIONS

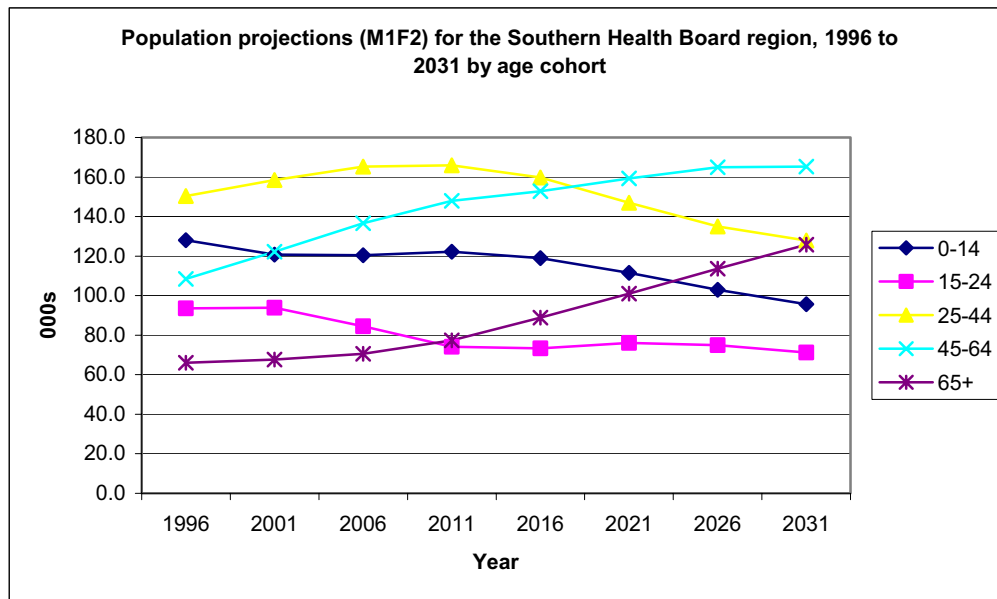
The Irish population, over the 15-year period from 2001 to 2016, is predicted to rise by over 5%. The SHB population projections are shown on Table 5.6 and Fig 5.7. However, for the 2001-2016 period, there is a predicted decrease for the 15-24 year age group of 22% and the 25-44 year age group is predicted to have a marginal increase of 0.8% by 2016. As these younger age groups are most affected by drug and alcohol problems, this knowledge is important in planning services.

Table 5.6 Actual & Projected Population: SHB 1996-2031

	Thousands					
	0-14	15-24	25-44	45-64	65+	Total
1996	128.0	93.6	150.4	108.5	66.1	546.6
2001	120.8	93.9	158.4	122.2	67.6	563.0
2006	120.5	84.5	165.2	136.6	70.6	577.4
2011	122.2	74.2	165.9	147.9	77.4	587.7
2016	118.9	73.3	159.7	152.8	88.8	593.4
2021	111.6	76.0	147.0	159.2	101.0	594.8
2026	103.0	75.0	135.0	165.0	113.7	591.8
2031	95.6	71.2	127.9	165.3	125.8	585.7

Source: CSO, 1996

Fig 5.7



Source: CSO, 1996

5.6 ESTIMATING THE REQUIRED CAPACITY FOR ALCOHOL TREATMENT SERVICES

Rush[82] developed a systems based approach to estimating the required capacity of alcohol treatment services for Ontario, Canada. This approach has also been used in other needs assessments[49].

There are four steps in the estimation:

1. Determination of the geographic area and the size of the population to be served.
2. Estimation of the number of problem drinkers and alcohol dependent drinkers within each population unit (the in-need population).
3. Estimate the number of individuals from step 2 that should be treated in any given year (the demand population).
4. Estimate the number of individuals from step three that will require service from each component of the treatment system.

Appendix 14 shows diagrammatically the method used to estimate the number of individuals from step 3 that will require service from each component of the treatment system.

5.6.1 Estimation of the number of problem drinkers

A variety of methods have been used in the alcohol field to estimate the number of drinkers and/or 'alcoholics' in the population. That number is then interpreted as the target population for treatment services.

Rush[82] used the *per capita* annual rate of alcohol consumption, of the number of persons aged 15 years and over, consuming 35 or more drinks per week and the estimate used was, 7.2% of the population.

Another London based needs assessment for alcohol services used trend information from the General Household Surveys (GHS) prevalence survey to estimate the number of men drinking over 50 units and women who drank over 35 units, which they estimated as 4% of men, and 1.4% of women.

This information on the number of men and women who drink more than either 35 units or the number of men who drink over 50 units is not readily available in Ireland.

In the absence of local epidemiological information, timely and methodologically sound data from other studies may be used[85].

The numbers of men drinking above the recommended 21 units per week is 23.8% in Barnet compared with 23% Cork and Kerry[6, 49]. However, the numbers of women drinking over 14 units is 14.1% in Barnet compared with 6% in Cork and Kerry. Therefore, there are some similarities between the areas although the percentage of women in Barnet may overestimate the number of problem women drinkers in Cork and Kerry.

Given that proviso, the author will use the percentages from Barnet to estimate local figures of the in-need population in Cork and Kerry.

5.6.2 Estimate of Demand for Detoxification using 'Rush' Model

Table 5.7 shows the steps in the estimation of the demand for detoxification.

Table 5.7 Estimate of demand for detoxification in Cork and Kerry using Rush Model and Barnet's estimate of in-need population.

	Population Cork and Kerry (Census 2002)	Percentage estimate of in-need population	Estimate of in-need population	Estimated demand for specialised treatment (15% of in-need population)	Estimated demand for detoxification (33% of demand for specialised treatment)
Men aged 15+ years	227,361	4%	9094	1364	450
Women aged 15+ years	232,449	1.4%	3254	488	161
Total	459,810		12,348	1852	611

Source: CSO, 2002 and Barnet estimates [49] and Rush model [82]

The total estimated demand for detoxification using this estimate from the Rush model is 611 people requiring detoxification in one year.

Cooper [86] has estimated that 91% of detoxifications are appropriate for community detoxification. Therefore, of 611 clients, 55 would take place in an in-patient setting and the remainder 556 would be community based.

5.7 INDIRECT MEASUREMENT OF PREVALENCE OF DRUG MISUSE IN IRELAND

A 3-source capture-recapture study of the prevalence of opiate use in Ireland was carried out in 2003^[87].

Table 5.8 summarises the results for Ireland outside of Dublin

Table 5.8 Results of 3-source Capture-Recapture method Ireland (25 counties) excluding Dublin

Year	Sex	Age Group	Estimate	Lower Bound	Upper Bound	Rate / 1000 pop
2000	M+F	15-64	2,526	1,893	3,639	1
2001	M+F	15-64	2,225	1,934	2,625	0.9

Source: SAHRU, 2003

However, while the results for the rest of Ireland outside of Dublin are available,

the estimates for the regions have not been published. The rate of 1/1,000 population given above if applied to Cork and Kerry would give an estimate of 580 in the region. However, this would be an overestimate because some counties have much higher rates of treated drug misuse. For example, in the five year period between 1998 and 2002, the average annual incidence of treatment for an opiate as a main problem drug per 100,000 population was 26.9 in Wicklow as opposed to 4.2 in Cork. Therefore, the rates given above cannot be applied uniformly throughout the whole of the rest of Ireland outside of Dublin.

Similarly, the National Advisory Committee on Drugs (NACD) is currently completing a report on multiplier and nomination methods, which is not yet available.

5.8 KNOWLEDGE OF EXISTING TREATMENT SERVICES IN CORK AND KERRY FOR SUBSTANCE AND ALCOHOL MISUSE

5.8.1 Introduction

The following is a description of treatment services in Cork and Kerry for drug and alcohol misuse. It was compiled following interviews with local service providers and from review of local directories on service provision. Services for detoxification, treatment services post-detoxification and services for the homeless, followed by Data from the National Drug Treatment Reporting System (NDTRS) is also reviewed.

5.8.2 Services for Detoxification

5.8.2.1 Detoxification for Alcohol

Detoxification for alcohol misuse currently takes place in a variety of settings. General practitioners undertake it in the community. This is usually undertaken in the person's own home.

In the hospital setting, detoxification takes place in a number of different inpatient locations throughout. These include acute medical wards, acute psychiatric wards and in some instances in the A&E ward in Cork University Hospital. Detoxification also takes place in the Cuain Mhuire treatment centre in Bruree,

Limerick on an inpatient basis. Fig 5.8 shows where the acute medical and psychiatric units are located. There is currently no specialist detoxification/addiction unit in the area for detoxification from alcohol or drugs. Detoxification is not currently routinely provided in the voluntary or health board addiction treatment centres in Cork and Kerry.

Fig 5.8.

5.7.2.2 Detoxification for Substance Misuse

5.8.2.2 Detoxification for Opiates

5.8.2.2 Detoxification for drugs other than alcohol

A number of GPs provide a service for methadone maintenance in the community in the Cork and Kerry area. There are two levels of training for GPs prescribing methadone in Ireland. Level 1-trained GPs are trained to provide methadone maintenance once the client has been stabilised on methadone by another service. Level 2-trained GPs are trained to a level where they may initiate methadone treatment including detoxification and stabilisation.

In the Cork and Kerry area, there are six GPs who have contracts with the Southern Health Board. These are contracts as level 1 GPs. These include two GPs in each of the following areas, Cork city, West Cork and Kerry. There are no GPs with contracts for level 2 service.

A detoxification service for opiates is rarely provided on an in-patient basis in the

area in the acute medical wards or the acute psychiatric wards. There is no specialist in-patient detoxification service.

5.8.2.3 Liaison Psychiatry Service

There is a psychiatric liaison service which is led by a consultant psychiatrist in Cork University Hospital. This provides a liaison service between the acute medical, surgical and A&E services and the psychiatric services. The service provides for the range of psychiatric diagnoses of which alcohol and drug misuse is one aspect.

5.9 TREATMENT SERVICES POST DETOXIFICATION IN THE CORK AND KERRY AREA

There are a number of health board and voluntary services for treatment of addiction post detoxification. These services are summarised below. Fig 5.9 shows the location of the different services.

Fig 5.9

5.9.1 Health Board Treatment (Statutory) Services

5.9.1.1 Arbour House

Arbour House is a drug and alcohol free non-residential treatment service providing a free service to clients with addiction, their families and other concerned persons. The treatment programmes are based on the Minnesota Model (12 step abstinence model) and the Therapeutic Community Approach[88]. There is a liaison psychiatry service from the Department of Psychiatry in the Mercy Hospital. A Specialist Registrar provides this service currently.

Arbour House provides a number of outreach Community Counselling and Advisory Services (CCAS). These are based in East Cork, Kerry, North Cork County, North Cork City and West Cork. Arbour House and the CCAS are services that are free of charge and are health board (statutory) services.

5.9.1.2 Voluntary Treatment Centres

In addition to the statutory services, there are a number of voluntary services in the area that provide addiction treatment services.

5.9.1.2(a) Anchor Treatment Centre (12 places)

This is a community based non-residential treatment centre in Mallow in North Cork providing services such as individual counselling and family support programmes.

5.9.1.2(b) Tabor Lodge Treatment Centre (16 places)

Tabor Lodge in Belgooley, Co. Cork offers a 28-day drug-free residential programme based on the Minnesota model. It caters for all types of addictions including eating disorders. Services offered include the residential programme for adults, family programme and a one-year aftercare programme. Weekly meetings are provided for each patient and a concerned person.

5.9.1.2(c) Talbot Grove (12 places)

Talbot Grove based in Castleisland, Co. Kerry offers a 30-day drug-free residential programme to those suffering from alcoholism or drug addiction. Treatment includes group therapy, individual counselling and lectures. A weekly aftercare programme is available for two years.

Clients who attend the voluntary treatment centres may be liable for a charge for the treatment. Private health insurance covers the cost (i.e. VHI/BUPA). A social welfare grant may also be available.

5.9.2 Other Residential Services for addiction in the HSE – South

The other residential services in the HSE-South include a voluntary adolescent treatment service, Cara Lodge, in Enniskeane, Co. Cork.

There are two voluntary half-way houses, which provide residential programmes, Fellowship House for men in Togher, Cork. Renewal Women's residence in Shanakiel, Cork provides a similar service for women.

5.10 RESIDENTIAL TREATMENT CENTRES OUTSIDE THE HSE-SOUTH

5.10.1 Cuan Mhuire Treatment Centre in Bruree (Up to 125 treatment places for the Munster area)

One of the treatment centres accessed by residents from the HSE–Southern Area, which is outside the geographic area is the Cuan Mhuire Treatment Centre in Bruree, Co. Limerick. This is a voluntary service and offers a residential programme including group therapy and counselling. It also offers a detoxification service.

5.11 SERVICES FOR THE HOMELESS

5.11.1 Background

As of January 2005, there are 434 homeless people known to Cork Corporation. Homeless people are known to have a high incidence of substance misuse. Vollm et al[89] found 70% of a homeless population that they sampled had a substance misuse problem. Local data of numbers of homeless people who had a substance misuse problem was not available at the time of writing. Speaking with local service providers to the homeless, different service providers estimated between 70% and 98% of the homeless that they came in contact with had substance misuse problems.

5.11.2 Current Services for the Homeless

There is a multidisciplinary team for the homeless in Cork city. The team comprises the following: Public Health Nurse (full-time); Consultant Psychiatrist (sessional); GP (sessional); Registered General Nurse (sessional); Community Welfare Officer service; Specialised Addiction Counselling Service Provider (sessional) and a Health Promotion Officer (sessional). The GP for the homeless currently oversees detoxification for patients who are suitable as an outpatient in conjunction with the hostels for the homeless. There is difficulty accessing inpatient detoxification for the homeless.

5.12 NATIONAL DRUG TREATMENT REPORTING SYSTEM (NDTRS)

5.12.1 Introduction

The Drug Treatment Centres make returns of client data to the Health Research Board (HRB) using a standard report form (Appendix 15). In Cork and Kerry, the drug treatment centres, which return data, include Arbour House and the associated CCS, Tabor Lodge and Talbot Grove. The six level-one trained GPs also return forms to the NDTRS. The NDTRS data from the SHB is considered here because it provides an overview of the work of the treatment centres. Data from the NDTRS by Jackson and Cronin[90] in the SHB has been reviewed for the period 1999 to 2003. Some of the key points from this review are summarised.

5.12.2 Numbers of Clients Treated in SHB -NDTRS

Fig 5.10 shows the increase in the numbers of clients treated over the five-year period 1999-2003 from 600 to 1800 per year. There were three Centres reporting in 1999 compared to 10 in 2003. This increase reflected a period of expansion in drug treatment services.

Fig 5.10 Numbers Treated SHB Area 1999-2003

Source: NTDRS, SHB, 2003

Source: NTDRS SHB, 2003

Fig 5.11 shows the number of clients treated in the different treatment centres. Arbour House and its outreach CCS treat about half the clients in the region. and the voluntary services treat approximately half.

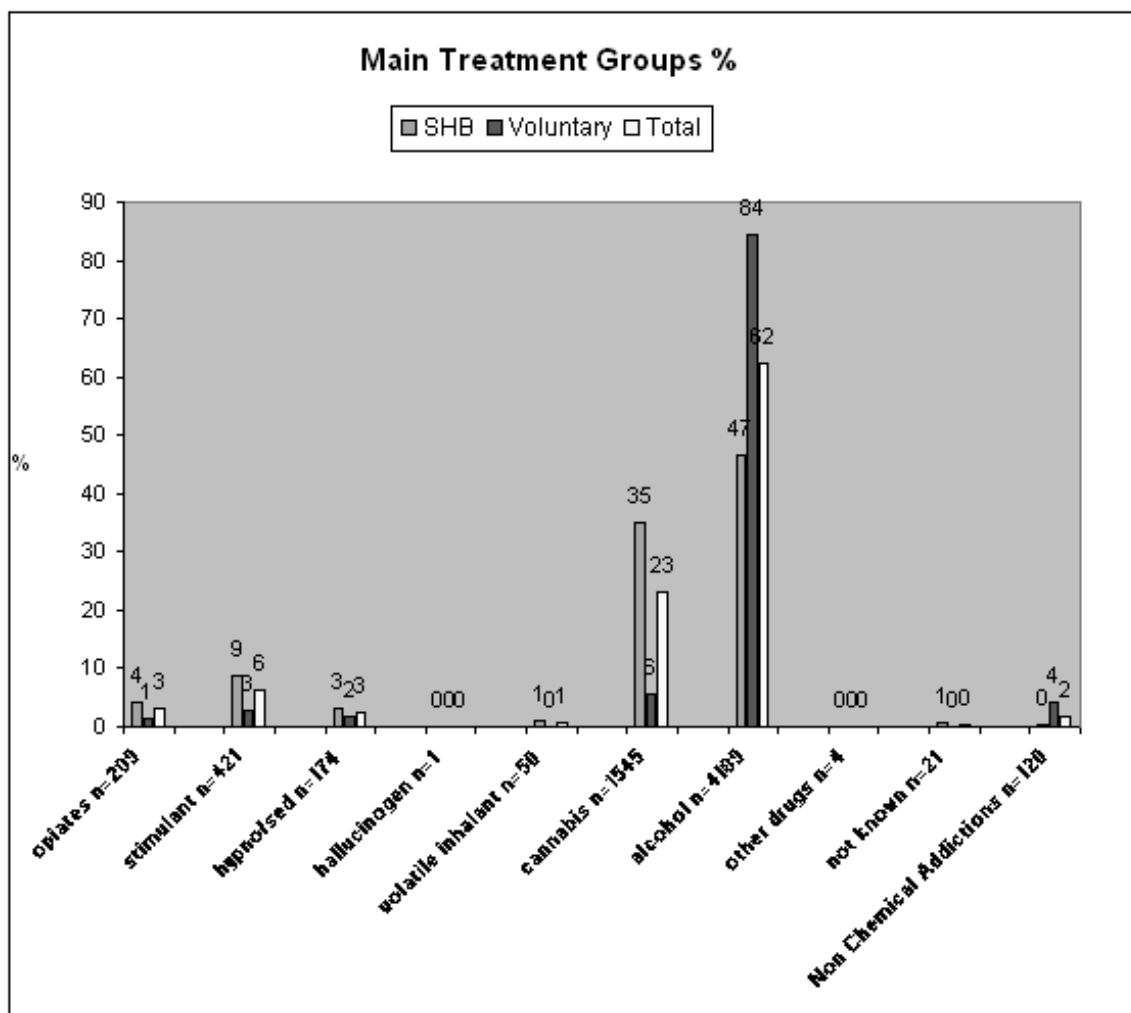
Fig 5.11 Number of Clients Treated by Treatment Centre (SHB) 1999-2003

Source: NTDRS SHB, 2003

5.12.3 Drug Treatment Groups

Fig 5.12 shows the main drug treatment groups. Overall 62% treated were for alcohol abuse, 23% for cannabis and 3% for opiates. The HSE-S (Cork and Kerry) treats more drug cases and voluntary centres treat more alcohol.

Fig 5. 12 Main Drug Treatment Groups (SHB) 1999-2003



Source: NTDRS SHB, 2003

5.12.3 Age and Sex

Fig 5.13 shows the breakdown of clients treated by main substance of abuse by sex. For the majority of both males (60%) and females (68%), the main substance of abuse was alcohol.

Fig 5.13

Source: NDTRS SHB, 2003

5.12.4 Detoxification

A variable on detoxification is included on the NTDRS form. However, it provides limited information in that there is no corresponding variable to specify for which substance they receive detoxification.

Table 5.9 Persons detoxified in SHB 1999-2003

Year	% of clients who received detoxification	Numbers of clients who received detoxification
1999	25.6	154
2000	7	80
2001	3	38
2002	2	27
2003	2	43

Source: NDTRS SHB, 2003

Table 5.9 shows that the number of clients detoxified in the SHB treatment centres has declined overall from 26% in 1999 to 2% in 2003. The reason for this decline is related to some of the residential treatment centres moving from a policy of inpatient detoxification to where most clients are now detoxified in an outpatient setting.

The breakdown of the 43 clients in 2003, who received detoxification, is as follows: 39 in Arbour House, 2 in the CCS and 2 by GPs.

5.12.5 Summary of drug and alcohol treatment in the SHB from 1999 to 2003 (NDTRS)

Alcohol takes up a large proportion of treatment services in the region. The HSE-South services treat more drug cases, than the voluntary services. Two thirds of substance abusers were male. The mean age of drug users was 13 years younger than alcohol users. Only 2% of those who received treatment had detoxification provided within the treatment service in 2003.

B. COMPARISON OF DRUG AND ALCOHOL SERVICES WITH OTHER REGIONS

5.13 COMPARISON WITH DRUG AND ALCOHOL SERVICES ELSEWHERE

5.13.1 Introduction

There may be difficulty in obtaining suitable comparable data in any needs assessment because of the need to find baseline data that can be compared and also finding a population that is similar to the population under study[91].

This is the first needs assessment for detoxification services for drugs and alcohol in Ireland. There is little information on current service provision with regard to detoxification within Ireland. Therefore, comparisons will be made with needs assessments for alcohol, which have been completed in the UK, and also recommendations for service developments in the UK. The costs of the suggested UK model will be estimated for an Irish setting.

5.13.2 Alcohol

5.13.2.1 Comparison with Barnet Alcohol Needs Assessment

The needs assessment for alcohol services recently completed in Barnet has already been mentioned. Barnet is a borough of London [49]. It is an urban setting and the population of Barnet is 314,564. The total population of Cork and Kerry is 580,6640 according to the 2002 census.

There is difficulty comparing a city area with a mixed but mostly rural area like Cork and Kerry. However, there are some similarities, which have been mentioned previously. The numbers of men drinking above the recommended 21 units per week is 23.8% in Barnet compared with 23% in Cork and Kerry[6, 49]. However, the numbers of women drinking over 14 units is 14.1% in Barnet compared with 6% in Cork and Kerry.

Table 5.10 shows current service provision is compared with the estimated need using the Rush method[82] for inpatient and outpatient detoxification. The figures relate to clients per year that are accessing services now and the estimated number of clients per year that will be needed in future. In the Barnet needs assessment, they refer to community detoxification, which is detoxification, carried out by a team providing the service in the home. It does not refer to detoxifications carried out solely by GPs. This team had only been in operation on a pilot basis since 2004. The inpatient specialist detoxification unit is already operational in Barnet. A specialist inpatient detoxification unit or an ambulatory detoxification service is not available in Cork and Kerry.

Table 5.10 Summary of need for detoxification within adult specialist alcohol services in Barnet.

Intervention	Current Provision Barnet	Estimated need Barnet
Community detoxification	60	319
Inpatient detoxification in specialist unit	32	31

Source: Barnet alcohol needs assessment[49]

Cook [15] recommends an integrated community response to alcohol misuse. The table shows the elements of this model, which relate to detoxification, and costs are included for an Irish setting. Estimated costs are included for the Irish setting.

Table 5.11 Building an integrated and prioritised community response to alcohol misuse^a

Item	Functions	Staffing	Cost pa (Euro)
1 Community Alcohol Team or Substance Misuse integration team	Functions multiple, flexible, exploratory and entrepreneurial but likely to include: (i) First wave of generalist services collaborations including GPs, general hospitals, district psychiatric and social services; (ii) Liaison with voluntary sector alcohol agencies including AA and Al-Anon; (iii) Immediate specialised service delivery and shared care through outpatient and liaison clinics; (iv) Direct/indirect assistance with detoxification; (v) Pharmacological treatments (disulfiram and acamprosate) (vi) Professional training; (vii)Overseeing and stimulating prevention; (viii) Special responsibility to liaise with district drug dependence Services.	Full-time consultant, half time SpR, full time SHO, 8 person team with variable skills mix drawn from CPN, SRN, SW, OT, psychologist, counsellor, with in and out attachments from voluntary agencies, secretarial support.	1,000,000
2 Access to 8–10 hospital beds in psychiatric setting (or larger facility shared by two districts)	Dealing with psychiatric co-morbidity, detoxification of severely dependent patients who cannot be managed in OPD.	Medical cover from liaison team. Full nursing cover, OT, psychology support, investigation facilities.	600,000
3 Services for the homeless drinker	Outreach shop-front, day centre and hostel facilities.	Likely to be provided by non-statutory agency.	240,000

a. Figures assume a population of c. 500, 000.

Source: Based on costs from UK estimate[15]

Marsden et al[20] have suggested a similar structure for drug misuse services (Appendix 3). However, because of the similarity the above model is costed and this service could provide a combined substance (alcohol and drug) misuse service in Cork and Kerry.

5.13.3 Opiates

5.13.3.1 Comparison with Opiate Services in other Regions in Ireland

For comparison of opiate detoxification services, it is useful to compare Cork and Kerry with other regions of Ireland. Outside of the HSE-Eastern Area, GPs deliver the methadone programme around Ireland. Level-1 trained GPs in the region can maintain clients on methadone but cannot initiate methadone treatment.

Level-2 trained GPs can initiate a methadone treatment programme. The GP is accredited following training as level-2. The service is run by GPs who either set aside time to run clinics in their own practice for methadone maintenance (GP costs 1300 euro per patient per annum). Alternatively, the HSE area provides a clinical space and employs GPs on a sessional basis (GP costs 65 euro per hour).

Up until the end of 2004, all of the former ten health board areas had contracts with level-2 trained GPs except the former North-Western Health Board and the Southern Health Board. These contracts continue under the new Health Services Executive. National support is available from the National GP Co-ordinator for level-2 trained GPs if a second opinion is required on a particular client.

As seen in Section 5.3.3, in July 2004, although the SHB has one of the lowest number (28) on the Central Treatment List in the country, it compares with the HSE-WA (26) where level-2 trained GPs are operational.

CHAPTER SIX RESULTS PART TWO: RESULTS OF INTERVIEWS WITH SERVICE PROVIDERS AND SERVICE USERS

6.1 INTRODUCTION

This section outlines the main findings of the interviews with service providers and service users (qualitative element) of this needs assessment. Common codes/concepts contained in the qualitative data were grouped together. The results presented here represent the predominant themes that emerged. Throughout this section, the health service providers are referred to as HSPs or Participants. The Specialist Addiction Counselling Service Providers are referred to as SACSPs. In-depth interviews were conducted with eighteen HSPs including a range of different professionals across the region.

Six in-depth interviews were held with health service users. They will be referred to as HSUs or clients in this section.

6.2 DEFINITION OF DETOXIFICATION

HSPs understood detoxification as a process of withdrawing the substance of abuse in a safe way sometimes requiring the use of an alternative medication

HSP2: "Detoxification in my experience refers to the process where by there is a deliberate effort to wean someone from the daily, perhaps dependent use of alcohol and it generally involves in-patient care. Certainly very structured care and it often requires the use of drugs such as, Chlordiazepoxide and vitamin supplements or occasionally chlormethiazole and vitamin supplementation. It generally takes one two three days, I know sometimes it usually takes an ambulatory out-patient setting which is most unusual in this city, in most cities in these islands, em,."

- Consultant in A&E Medicine

A small number of HSPs equated detoxification with permanent abstinence from the drug of abuse.

HSP 1: "I mean I have tried to detox on occasions but it I don't know did it ever work and it tends to be a euphemism for maintenance. Patients come in, they are detoxing, they want Librium, they get Librium, I hope I don't see them too soon again and again the next time they'd be detoxing again so its not detoxing by my definition. That's what they call detoxing.....It doesn't lead onto abstinence."

- GP

6.3 EXPERIENCE OF DETOXIFICATION

6.3.1 Alcohol

HSPs were asked about their experience of detoxification within their own practice setting. Medical HSPs provided detoxification services for alcohol. The numbers that the HSPs dealt with in relation to detoxification varied widely. Consultants, whether Psychiatrists, A&E or Medical, reported dealing with cases of alcohol withdrawal more frequently than GPs. SACSP do not provide detoxification themselves directly but were able to comment on the numbers in their service who had been through detoxification.

HSP8: "In two hundred and twenty one people treated last year, I'd say, let's say fifty to sixty would have had a detox completed on admission. That would be around a quarter."

- SACSP

HSP12: "We have particularly, and we would have, figures that would suggest that we would have forty to fifty alcoholics in the practice, experience would confirm that we certainly have forty to fifty patients at least who have, who are in the severe category for alcohol dependence syndrome ... yes, we detox them here really... Eh, no more than four to five cases per year do we institute a whole management programme for, for detox, you know, and putting them on chlordiazepoxide and vitamin supplements and all that really, but the, and I would imagine no more than one to two cases a year, do we need inpatient detoxification for an alcoholic."

- GP

6.3.2 Drugs other than Alcohol

6.3.2.1 Opiates

A minority of HSPs had experience of dealing with detoxification from opiates. A number of Psychiatrists said they did not provide a service for methadone detoxification and therefore rarely saw patients requiring detoxification for opiates.

HSP 15: “..in regard to serious drug abuse as in heroin and we, we don't really see it. Em, at my instigation there's a hospital policy nobody, nobody uses methadone in the hospital, on the premises.. we might once or twice perhaps have detoxed people without methadone...a combination of phenothiazines and benzodiazepines”

- Psychiatrist

In general the GPs who were interviewed did not meet or treat people with heroin addiction. One GP had met five patients in the last year who were taking heroin. He commented that a lot of the heroin users would have come from outside the Cork area originally and then moved to the area. This observation about heroin users coming from outside the area was made by a number of HSPs. One SACSP had met 8 new clients who were using heroin in the previous year.

HSP 9: “...five in the last year on heroin, on heroin. Some of those would, a lot of the heavy alcohol abusers would be people who come to Cork, got off heroin, from Dublin or England, come to Cork and then switched over to alcohol.”

- GP

HSP7: “In the last year I'd say I have seen about maybe new clients that I've never seen before, I'd say there is probably about 8 new clients I'd say in 2022 up until now. They would have primarily been heroin users.”

- SACSP

6.3.2.2 *Drugs other than Opiates*

HSPs had very little experience of clients requiring detoxification from drugs other than opiates. However, a few did mention that benzodiazepine abuse was a problem that they encountered. One because of perceived non-compliance of clients, identified difficulties with detoxification from benzodiazepines.

HSP 3: “.. people are trying to do a home detox with benzodiazepines and that, they tend not to be very compliant, they do, they tend to be more drug-seeking more dependent they use more than prescribed, so they're not very compliant with it. So that's a more difficult one.”

- SACSP

6.4 PROCESS OF DETOXIFICATION

Medical HSPs used chlordiazepoxide (Librium) for the process of detoxification from alcohol. A large number used vitamins also in this process. The length of time over which people received detoxification varied from 3 days to 2 weeks. Many HSPs said that they varied the schedule according to the needs of the patient.

HSP 9: "I would basically then start prescribing Librium, it's only Librium I prescribe."

- GP

HSP 10: "...we'll say the everyone uses it, we're familiar with it and it's the easiest to manage...Vary it. I suppose I'd typically starting off, between thirty and sixty milligrams and wean down maybe over two weeks."

- GP

One SACSP said that he was aware of GPs who prescribed alprazolam (Xanax) or chlormethiazole (Hemineverin) for detoxification and said that he felt there was a need for a consistent approach to prescribing.

HSP 3: "I suppose we find Librium is the easiest stuff for us to deal with, it's also the easiest when people who are coming in, and it's the one we find that handiest whereas a lot of GP's now seem to be using Xanax, Heminevrin, still pops up its head occasionally, you know, and you know some GP's you can suggest that for, and others you can't, or you might do it sometimes they do, it has little effect...If there was a bit of consistency around that, it would be, it would be very helpful."

- SACSP

6.5 CURRENT SERVICES

6.5.1 What is working well in the current services?

Interviewees were asked their opinion about what was working well in the current services in relation to detoxification. A range of views was expressed. A number replied that they felt nothing or very little was working well in the current services. However, Psychiatrists particularly commented on the fact that the detoxification

service that they offered for alcohol was working well. One SACSP commented that the in-patient detoxification service worked well but the difficulty was getting a client into that service.

HSP11: “Well the only thing that works well is we keep them in for a short time and they go, that’s the only thing that I can see that works well. They come in, they don’t use up too much of our time, we deal with them fairly effectively..”

- Psychiatrist

HSP 3: “..the relationship with the psychiatric unit in Tralee is working quiet well... that works very well, the difficulty is getting them there to be detoxed.”

- SACSP

The health service manager commented that the service offered by GPs worked well and that there were improved links being established with the counselling services. One SACSP said that they had made a transition from inpatient to outpatient detoxification within their services and that was working well.

HSP 5: “what is working well I think is the, the services the GP’s provide to, to individuals and I think that there is, that there is quite a number of links now being established between GP’s and the non-medical counselling services..”

- Health Service Manager

HSP 8: “I think out-patient detox or alcohol abuse is working well. ... that is a big change in our service in the two years and we’re very satisfied with how its going as in transition to outpatient detox.”

- SACSP

6.5.2 What is not working well with current services?

A wide variety of issues emerged when HSPs were asked what was not working well in the current services for detoxification. The services are fragmented.

6.5.2.1 Access to Treatment Services following Detoxification

The issue of clients having detoxification but not accessing follow on treatment

services was raised by a number of service providers.

HSP10: "I mean, the inspector of mental hospitals says about a quarter of all psychiatric admissions are alcohol-related....very, very few of those people end up in treatment services, no matter what it is, so that is a problem, it's that they go to step one, they never, there's no, there's no initiative that gets them further along the line."

- GP

HSP 11: "What doesn't happen is that, is that, given that we've taken them, given that we've given them the tools so that they can walk around, talk to their relatives, be half-way decent to the person next door, without a tank full, of alcohol on board then what happens next is non-existent."

- Psychiatrist

6.5.2.2 *Lack of Guidelines between Detoxification and Treatment Service*

Medical HSPs commented on the lack of guidelines and procedures between their service and the SACSP.

HSP 4: "I've been to Arbour House em, we'd sort these names and numbers out but I haven't visited the units and em I haven't really met the staff and we haven't really conducted joint guidelines. So its always been opportunistic ad-hoc, people might ring around, they might say oh yes, Bruree, or Arbour House has a facility you might get a sympathetic psychiatrist who turns up on the day and he says yes. But again that's ad-hoc."

- A&E

6.5.2.3 *Lack of Support for GPs managing Detoxification currently*

HSPs including GPs and non GPs said that there was a need to provide support for GPs.

HSP 12: "If you're dealing with alcoholism, primary care is a very lonely place to be, and I wouldn't mind saying that, it's a very lonely place to be if you're a GP trying to deal with all the problems that alcohol consider, conc-, or causes."

- GP

6.5.2.4 Special Groups

Some groups of clients were identified as having particular difficulty accessing appropriate services. These were dual diagnosis, homeless and young people.

6.5.2.4(a) Dual Diagnosis

A number of HSPs spoke about the issue of dual diagnosis where clients have a psychiatric problem as well as a problem with addiction. One HSP said that patients with dual diagnosis were difficult to treat in the current community counselling services because the service required that their clients be drug free (including freedom from prescribed medication) to access the treatment service. One HSP said that sometimes these patients had more attention focused on their primary psychiatric diagnosis than their addiction in the current service.

HSP 10: “..you’re not allowed take any medications and all that kind of stuff when you were coming here, which has made some people very sceptical about the service, is it’s so difficult to get in that is changing over time like, but that’s also an issue, is that if people have other, particularly psychological issues, to deal with them in this kind of facility is quite difficult because we don’t have the back up to do for instance, it’s very difficult to say treat somebody with schizophrenia in our type of programme...”

- GP

HSP 16: “At the moment I would say the pathway is unclear and for people with dual diagnosis addiction and psychiatric disorder they tend to be managed by the psychiatrist and I think the psychiatric diagnosis tends to be the focus of attention more than the addiction, which I think you know is in a sense not ideal.”

- Psychiatrist

6.5.2.4(b) Homeless

A number of HSPs spoke of the difficulty of getting detoxification for homeless people in the city and some spoke of the need to provide a service for the homeless.

HSP 9: “I suppose just in summary ... hospital detox....It’s just not available. It’s definitely not available for my population (homeless), okay. And, you basically have to go down on your knees to try to get somebody

in and I, I don't think any, in the year I got nobody in."

- GP

HSP 5: "ninety per cent of people that are homeless suffer, have alcohol or drug problems and I think that we need to be in a position to take those people and give them something if they want it. They have done it in the States where they have put people in what they call drunk tanks and so on and get them to sober up for a while. Now whether that's the solution or not, it seems to me that it's better deal then lying on a cold pavement you know."

- Health Services Manager

6.5.2.4(c) Young People

HSPs raised the issue of young people having detoxification inappropriately in an adult psychiatric ward and the lack of a suitable service for this age-group.

HSP 13: "... they came to us looking for, you know, admission for detoxification. Particularly for their client group which is a younger aged group... And they're certainly you know, these are, you know I think they from a range of about twelve to eighteen may....a few of them have come in to be detoxed here and it's entirely inappropriate, what happens is, these are young people who, who, you know, we want to sort of steer away from psychiatric services because they tend to you know have...you know, potentially developing personality disorders, and they get worse actually when they come into our services"

- Psychiatrist

HSP 16: "I have diagnosed alcohol dependence syndrome in young women under the age of 18 ... certainly there would seem to be some kind of adolescent substance misuse service, I would actually say very urgently required because if these people aren't caught at this stage I mean their life expectancy, you know they are very, very vulnerable group of people and very common."

- Psychiatrist.

6.6 FUTURE DEVELOPMENT OF THE SERVICES FOR DETOXIFICATION AND TREATMENT

6.6.1 Development of Services in General Practice

6.6.1.1 Alcohol

The vast majority of HSPs including GPs themselves thought that there was potential to deal with more detoxification within general practice. Most said that support for GPs would be necessary to achieve this.

HSP18: “.. alcohol is a huge problem, you know, five percent ten percent, there’s a lot of people out there with alcohol problems, so probably an awful lot of them could be, could be handled at a GP level, eh. So, we’re dealing at the deep end of things here so my views really, I think GPs would be able to comment more but I’m sure there must be eh, more that are out there.”

- Psychiatrist

The views offered in relation to what specific type of support would be required varied. Some thought that training for GPs was necessary. Others thought that a professional support system was essential e.g. under the supervision of alcohol and drug services working with the GP. One GP suggested a similar structure to palliative care for the development of alcohol and drug services generally. Another suggested a community addiction team.

HSP11: “I personally think that it should occur at home under GP supervision or under ah, you know, supervision of the alcohol and drug services directly so you know, that would be my view.”

- Psychiatrist

HSP 12: “I would see, a team approach.... there should be a team comes down to an area where either group GP’s or a GP can meet and say okay how do we develop the service within this area and how do we resource it and that may mean, yes, the outreach programme. I’m talking about, the over-view and the palliative care approach of the consultant who deals with it, the outreach nurses or out reach counsellors or psychologists to whoever they are and that we all then decide how do we all link ...”

- GP

HSP 9: *"..community addiction counsellors and maybe, some sort of team approach where you could say, I'd refer, I'd commenced Mrs. Murphy on Librium, or Librium detox this morning and you could ring somebody up and say would you call in and see her tomorrow and see how she's getting on, you know... Like almost like a community mental health team....but more of the community based addiction team."*

- GP

A minority felt that more detoxification could not be carried out in practice.

HSP 10: *"I mean there will always be the GP's who aren't prepared to undertake it for whatever reason, and there's nothing, well there is something you can do in regards education to do that, but most GP's do what they can and the reason they refer them on elsewhere is because they're, they don't feel confident or don't have the facility to manage."*

- GP

6.6.1.2 *Drugs other than alcohol*

A number of GPs thought that the GP service for detoxification other than alcohol could be developed in the region. One GP felt that there should be a specialist GP in addition to a specialist unit. Another GP thought that back-up support was necessary for GPs providing detoxification for opiates.

HSP 9: *"I think that GP's are very well aware, are very well capable of dealing with it (detoxification from opiates) after that as long as they still have the contact and the support of the specific clinics, nearby that they can ring up for advice or refer back very quickly their clients who are causing problems and maybe have slipped."*

- GP

HSP 12: *"with either as an outpatient or an inpatient really and probably I would feel that more so for the drug abuse really, that there may need to be a specialist GP as well as a specialist unit to deal with it really because of drug prescribing and all that really."*

- GP

Some HSPs commented on the issue that there might be an increase in the number of heroin addicts if a service for detoxification was not provided. Some HSPs were not in favour of expanding the methadone service in the

HSP 7: *“that the word gets out that the Health Board are providing a service now for maintenance or detox and you do get an influx all of a sudden, I don’t think there is any harm in doing it, in being prepared anyway and having a protocol there that’s going to help people deal with professionals across the board to deal with it. I can’t see the problem there or the justification of using that as an argument.”*

- SACSP

HSP 9: *“So, yes, if there was something available in Cork it probably would increase the numbers, I think it’s very, it’s very difficult you know. Because you hate to be seen as part of a problem that escalates as well because you started the service.”*

- GP

Some HSPs were not in favour of further development of the methadone service in the area because of the problems with the service that have occurred elsewhere.

HSP18: *“...you know changing peoples dependence from one illegal to a legal one or prescribe what’s given the figures in relation to the methadone abuse problem in Dublin and well over fifty percent of the prescribed methadone ends up back on the street being traded as well and then by you are holding some peoples problems at bay you are developing new problems in other people so we certainly eh wouldn’t be in favour of a methadone service in the area.”*

- Psychiatrist

6.6.2 Development of Specialist Drug and Alcohol Service

6.6.2.1 Psychiatrist Specialising in Addiction

A number of HSPs suggested that there was a need for a Psychiatrist who specialised in the area of alcohol and drugs. One Psychiatrist said that such a service would need help from the medical service suggesting a dedicated three or four sessions a week.

HSP17: *“...in my view we need a consultant psychiatrist in the alcohol services. Particularly in the area of drugs if they were involved in that from what I’m aware of their service at the moment its not eh, not very well developed in Cork.”*

- Psychiatrist

6.6.2.2 Specialist Detoxification Unit

A large proportion of HSPs suggested developing a specialist unit for detoxification of alcohol and drugs. A number suggested that such a unit should be separate from the psychiatric unit. Some suggested that there should be a multidisciplinary team unit. Others felt that one large unit in the County would not suit areas distant from the city and there was a need to provide smaller more local units. Others expressed concern about the cost of such a unit.

HSP 4: "I don't expect ever to see a facility in my lifetime in this city which is adequate to the requirements but I would hope that we would see a facility that's better than anything we have at the moment.... In other words if they can take two, four, six cases a week that would be a quantum leap. As opposed to the two or four a month, which it seems I accommodate at the moment, which is again adhoc and you know its all kind of a sticky plaster type approach. But if there was a dedicated withdrawal facility in the city or county or wherever that said, right lads, we'll set out to deal with two, four, six a week, that would be a huge leap for war d, I would think."

-Consultant in A&E Medicine

HSP 18: "... detoxification facilities there needs to be a geographical spread and its probably not realistic to say that somebody in detoxification in Skibberreen and its not there going to go up to Cork for it."

- Psychiatrist

One HSP said that it was more important to consider detoxification in the home setting rather than developing a specialised unit.

HSP 11: "I think having a central detox unit is a waste of money because that's not the problem, you know. Really we should be developing good systems of having detox at home and having people trained to monitor them ..."

- Psychiatrist

6.6.3 Need for integrated services for drugs and alcohol

6.6.3.1 Need for Liaison Workers

Liaison workers who would work between services particularly between

detoxification and treatment services were identified as a way of increasing the number of clients who accessed treatment services post-detoxification particularly. The Consultant in Accident and Emergency suggested employing an alcohol specialist nurse in the A&E Department.

HSP 7: "I think from day one that there is a kind of a link worker or whatever would be involved in that unit working with that client doing some preparatory work for recovery or seeing their potential if there is a potential for change, assessing that, do you know what I'm saying so as the whole thing is more of a kind of a linked process all the way through."

- SACSP

6.6.3.2 *Need to Develop Guidelines or Protocols*

Some HSPs commented on the need to develop protocols or procedures for admission to hospital when the detoxification is not feasible in the community. One of the SACSP wished to have referral letters for clients referred from the psychiatric service to the counselling services.

HSP 5: "if somebody needs to be put to bed it shouldn't be how are we going to manage that, we should have a system, protocol, procedure..."

- Health Service Manager

6.7 ROLE OF OTHER COMMUNITY SERVICES IN DETOXIFICATION

6.7.1 *Role of Community Hospitals in Detoxification*

A number of HSPs thought that there could be a role for detoxification in community hospitals but expressed reservations regarding safety for staff and also ensuring that a patient with DTs would not be suitable for a community hospital. One HSP suggested that the role of the community hospital needed to be reviewed in the widest sense so that maximum use could be made of the community hospital by the health service.

HSP10: "Alcohol yeah. You have to be careful, when you factor in other things. I suppose the level of staffing is one thing, the types of staff that you have in these situations would be very different to what you'd have in a community hospital, we need to be very, very sure... You don't

want somebody going into the DT's in community hospital, you know."

- GP

6.7.2 Role for Public Health Nurses in Detoxification

Some HSPs expressed the view that Public Health Nurses (PHNs) had a role in identification of people with alcohol problems but most had not foreseen a role for the PHN overseeing detoxification.

HSP10: "I've never thought of them kind of, getting involved in the detoxification process per say, but they very often will have contact with people that we wouldn't have and see them in different situations so that's why in identification in particular they can be very useful."

- GP

6.8 RESULTS OF INTERVIEWS: HEALTH SERVICE USERS

This section describes the results of the qualitative research, which involved six in-depth interviews with clients who had been through the process of alcohol detoxification within the previous three months.

6.8.1 Understanding and Experience of Detoxification

HSUs understood the process of detoxification and provided a definition of detoxification although one HSU said he knew '*nothing about it*'.

HSU 7: "my Psychiatrist said to me you need to go in and get rid of all toxins from your body, that's all I understood by it you know."

- Female, age 48 years

Half of the HSUs had experienced going through detoxification on one occasion prior to their current admission to the treatment centre. The remainder had experienced multiple detoxifications in different settings, as an outpatient by their general practitioner and in different psychiatric hospitals. All HSUs had long histories of alcohol abuse of over 15 years in the majority of cases.

One HSU chose to go through unmediated detoxification on his first experience and then subsequently learning how to self medicate so that he could detoxify himself.

HSU2: *“Yeah, when I, the first time I did it myself...I nearly went off my game..... the sweats, cold sweats, hot sweats...Hallucinations and everything yeah.. Sick and empty reaching, it’s just unreal.”*

- Male, age 36 years

HSU2: *“...with taking Librium and Zanax... But say like the last, we’ll say I detoxed myself before I came in here now... Yeah, well I went to my doctor and just took my gear myself and then, and there was no, it was just a normal day...But eh, you know, it takes away the shakes and the sweating and the anxiety and the fear, takes away everything, the tablets are great, the Librium, and you see where it would take some fellows maybe three or four days to come down off it, I could come down off it in one day.”*

- Male, age 36 years

6.8.2 Access to Services

6.8.2.1 Access to Detoxification

Accessing to detoxification services as an inpatient or in a general practice setting was achieved without difficulty for most HSUs. However, one participant who also suffered from manic depression, experienced a six-week delay before getting admitted for detoxification to the psychiatric ward and expressed the view that she should have had priority of admission over those suffering from alcoholism alone.

HSU6: *“That’s right when I eventually did get into GF there was this man inside in his late 20’s and he was to go to Tabor Lodge and they were detoxing him inside in GF and like he only lasted a week and a half or something down here, drank again and ended up again in GF and like I thought at the time you know I was spending six weeks and I have manic depression. They were actually giving priority to alcoholics...I didn’t think that was appropriate no because they needed Librium and go to their meetings and move back into the treatment centre or something else..”*

- Female, age 40 years

6.8.2.2 Access to Treatment Services Post-Detoxification

Access to treatment services post-detoxification, was generally viewed as timely and without delay. HSPs received information on treatment services from a variety of sources including their general practitioner, psychiatrist and friends.

HSU 1: "the following day was the New Years Eve and I went down to see his mother, and she had been in here as it transpired and she hadn't drank for eight or nine years I think. So she gave me the background to it, you know, and the story about the place and she said why don't you go down, she gave them a ring and go down and have a chat.."

- Male, age 50 years

A number had already been to this treatment centre or had experience of other treatment centres in the region. Most participants self-referred to the treatment service. The majority had a very short time to wait to enter the treatment programme following their initial assessment. However, one participant had experienced a long delay between detoxification and treatment.

HSU6: "No and there wasn't the waiting list there is now for (Treatment Centre) either..... I was waiting this time 5 weeks. That's when the doctor gave me 2 days supply but I did find that difficult and in the end I broke out and up until 2 days before I was actually coming here."

- Female, age 40 years

However some HSPs described difficulty experienced by others in getting access to inpatient beds.

HSU5: "Because I've actually been in there and I've heard people coming in and seeing people and they haven't, there was no beds. I mean none at all, so I couldn't do nothing for them. Maybe they give them a prescription to go to the chemist and get Librium, and give them directions how to take it, but that would be as much as they could do, yeah, if there is no, they'd be a shortage of beds and there is no where to put them so..."

- Male, age 32 years

6.8.2.3 Suggested Improvements to the Service for Detoxification

The main concern for the future development of detoxification services was that more in-patient beds be available for easier access to detoxification. A number also thought that detoxification should be carried out in a separate unit and thought that the psychiatric ward was not an appropriate place for detoxification for alcohol.

HSU3: "Maybe it should be extended and more beds available but not to fill them you know like when they started cutting the SHB they were closing wings of hospitals and leaving beds available like there were beds available in wards and not being used. Now there is nothing wrong with throwing 10 extra beds into GF and leaving them lie idle. Those 10 beds would be there if needed immediate attention rather than saying we will give you some Librium you know and you can go home now and we'll see you in the morning. Some people may not make it back in the morning, not through suicide but may just forget to come back."

- Male, age 45 years

HSU 2: "I suppose it would be no harm if there was a proper place for detox treatment, you know what I mean, because what you go through is pure hell."

- Male, age 36 years

HSU 6: "psychiatric wards really isn't a place for alcoholics is it?"

- Female, age 40 years

**CHAPTER SEVEN RESULTS PART THREE: RESULTS OF THE
QUESTIONNAIRES SERVICE PROVIDERS (QUANTITATIVE)**

7.1 INTRODUCTION

This chapter describes the results of the questionnaire survey (quantitative results). The questionnaire was circulated to psychiatrists, medical consultants who engaged in acute medical on call, Consultants in Accident and Emergency Medicine, GPs and Specialist Addiction Counselling Service Providers (SACSPs) in Cork and Kerry.

7.2 RESPONSE RATE

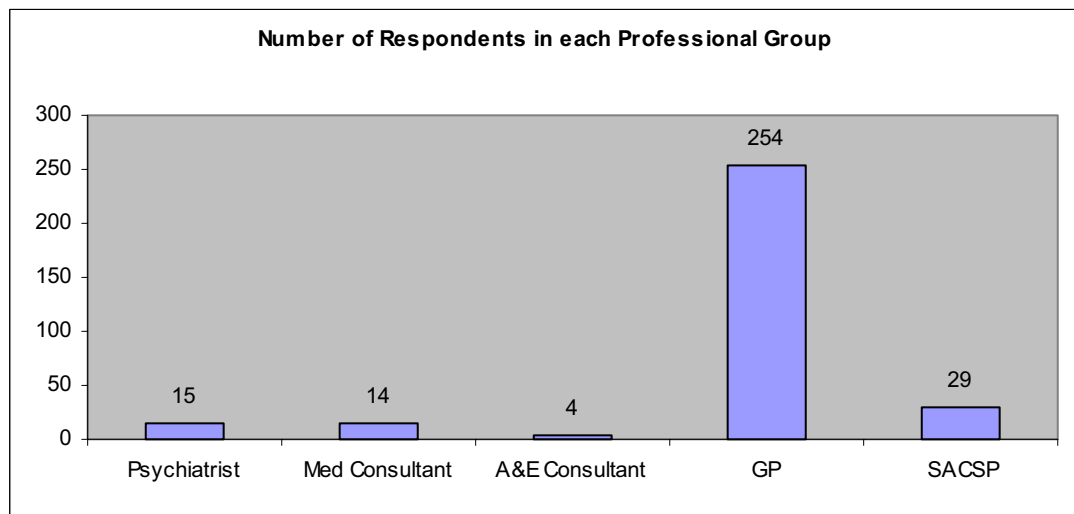
The overall response rate to the professional's questionnaire was 62%. Table 7.1 gives a breakdown of response rate by professional group.

Table 7.1 Response Rate

Professional Group	Psychiatrists	Medical Consultants	Consultants in Accident and Emergency	GPs	SACSP	Total
Number of questionnaires returned	15	14	4	254	29	316
Total number of professionals in group	30	19	4	423	36	512
Response rate (%)	50	74	100	60	81	62

The largest group of respondents were GPs (Fig 7.1).

Fig 7.1 Respondents by Profession

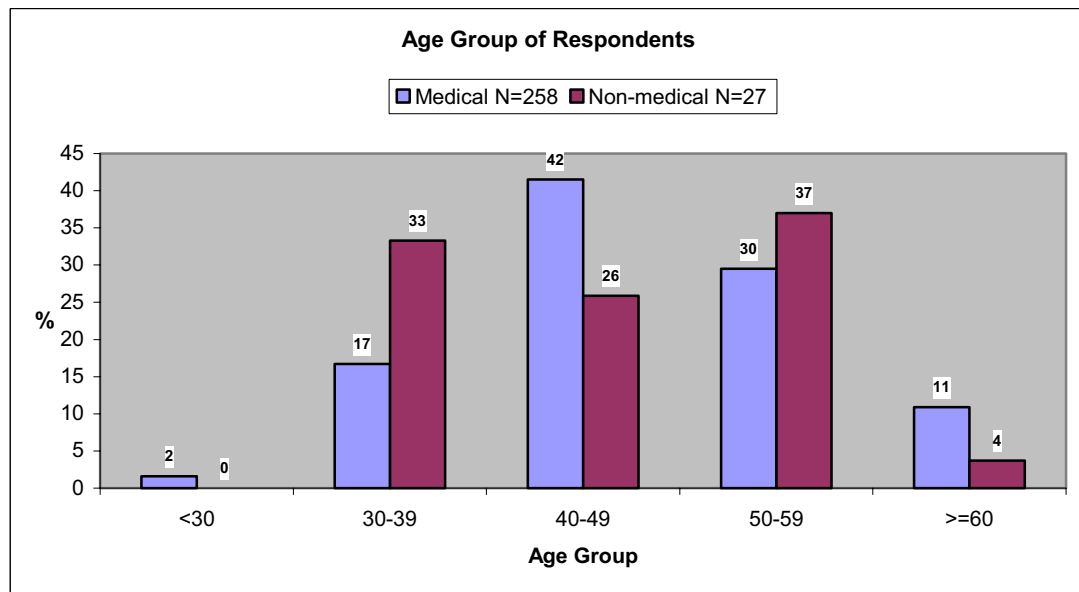


Of non-medical respondents, 48.3% (14) work in health board facilities, the remainder 51.7% (15) working in the voluntary sector.

7.3 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Fig 7.2 compares age groups of medical respondents overall with the SACSP group (missing answers are excluded). As a percentage, there are twice as many SACSP compared to medical in the 30 - 39 year age group.

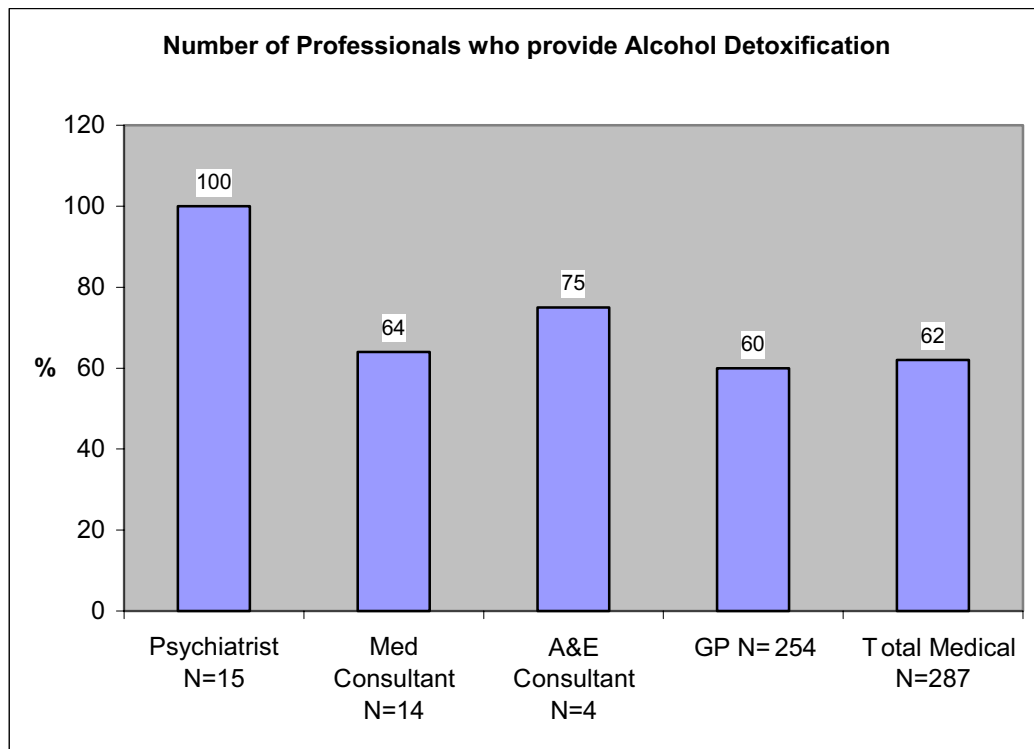
Fig 7.2 Distribution of Respondents by Age-Group



7.4 PROFESSIONALS ENGAGED IN ALCOHOL DETOXIFICATION

Overall, 62.4% (179) of medical respondents said that they undertook detoxification of clients for alcohol. All Psychiatrists who responded engaged in alcohol detoxification while 60% of GPs did so. Fig. 7.3 gives a breakdown of those providing alcohol detoxification by profession.

Fig 7.3 Percentage of Professionals who provide Alcohol Detoxification



7.5 ESTIMATED NUMBER OF PATIENTS DETOXIFIED FOR ALCOHOL WITHIN THE PREVIOUS YEAR

Medical respondents were asked how many patients they had detoxified approximately within the last year. The estimated mean number of patients detoxified by psychiatrists was 33 compared with 6 by GPs. Fig. 7.4 outlines the mean number of patients detoxified based on the professional's own estimation.

Fig. 7.4 Mean estimated number of Patients detoxified from Alcohol within the previous year by Professionals
within the previous year by Professionals

Table 7.2 shows the professional group's estimate of the total numbers detoxified for alcohol within the previous year. This would imply that an important proportion of detoxification for alcohol takes place in the community by GPs.

Table 7.2 Total estimated numbers Patients detoxified for Alcohol within the previous year

Professional Group	Total Estimated Numbers of Patients Detoxified for Alcohol in Previous Year
Psychiatrists	495
Medical Consultants	210
Consultants in Accident and Emergency	35
GPs	966

7.6 SETTING FOR ALCOHOL DETOXIFICATION

7.6.1 Medical Respondents

Respondents were asked in what setting they undertook detoxification for alcohol. 87% of psychiatrists said that they engaged in detoxification as in-patients in psychiatry, while 60% undertook detoxification in psychiatric out-patients. 57% of medical consultants provided alcohol detoxification in acute medical wards, with 21% doing so in A&E ward. 14% said that they managed detoxification in each of the following, psychiatric out-patients, community hospital and as a patient in the community. 75% of A&E consultants dealt with clients requiring alcohol detoxification in the A&E ward. 58% of GPs undertook alcohol detoxification of patients in the community.

Only 4% of GPs used the community hospital setting for detoxification of alcohol. Seven percent of psychiatrists and 14% of medical consultants said they used community hospitals for detoxification. At present, community hospitals are used infrequently for alcohol detoxification.

Fig. 7.5 Setting for Alcohol Detoxification – Medical Service Providers

7.6.2 Specialised Addiction Counselling Service Providers Respondents

7.6.2 SACSPs

Twenty three (79.3%) of Specialised Addiction Counselling Service Providers indicated that detoxification for alcohol occurred within their service. Of those

7.6.2 Specialist Addiction Counselling Service Providers

Twenty three (79.3%) of Specialist Addiction Counselling Service Providers indicated that detoxification for alcohol occurred within their service. Of those who responded 59% said that this service was provided by a GP who worked specifically within the service. 52% said that alcohol detoxification was provided by the clients own GP.

Fig. 7.6 Provision of Alcohol Detoxification Services in Cork and Kerry

Other settings for detoxification mentioned in the comment box by medical service providers were as follows:

- a. Home.
- b. Depends on severity of symptoms, patient preference and availability of beds.
- c. Cuain Mhuire, Bruree.
- d. Specialised units for alcohol detoxification.
- e. As a patient in a general practice setting.
- f. Some are referred to psychiatric ward. Some to Talbot Grove.

7.7 ACCESSING OTHER SERVICES FOR ALCOHOL DETOXIFICATION

7.7.1 Access to Services outside of own service for Alcohol Detoxification

Both medical and non-medical respondents were asked if they accessed services outside their own service for alcohol detoxification. Overall 74% accessed other services.

Seventy five per cent of A&E consultants used acute medical ward for detoxification. For all other professional groups (excluding psychiatrists), psychiatric in-patients were the most commonly reported service used outside their own.

Fifty five per cent of non-medical professionals and 39% of GPs said that they used Cuain Mhuire in Bruree. The use of Cuain Mhuire was widespread throughout the region with somewhat lower numbers accessing the service from South Lee Rural and West Cork areas.

Thirteen per cent of psychiatrists and 10% of non - medical personnel outlined that they used community hospitals. Fig.7.7 describes the breakdown of access to each service by professional group.

Fig. 7.7 Professionals use of services outside their own service for alcohol detoxification

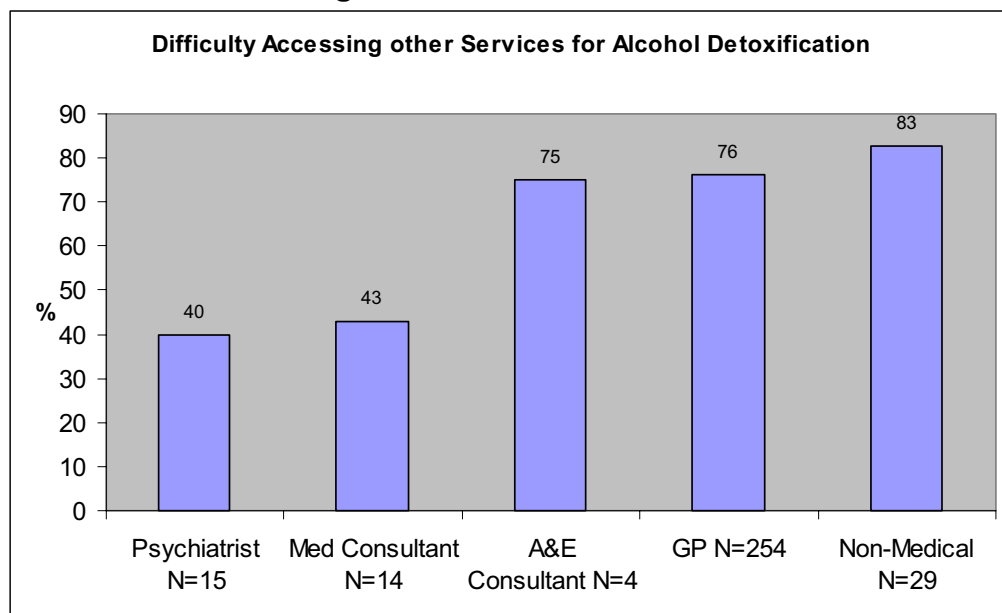
One respondent replied in the comment box saying that clients were referred to hospital for alcohol detoxification in his/her service.

7.7.2 Professionals' Difficulty Accessing Services outside their own for Alcohol Detoxification

Overall, 65% of respondents had difficulty accessing services outside their own service for alcohol detoxification. Different service provider groups varied in their perception of difficulty accessing other services. Forty per cent of psychiatrists and 43% of medical consultants reported difficulty. Other groups reported much higher levels of difficulty accessing other services for alcohol detoxification. Seventy six per cent of GPs services and 75% of A&E consultants had difficulty accessing other services. The highest reported difficulty was 83% of non-medical service providers.

Fig. 7.8 details the breakdown by profession of difficulty accessing services outside their own service.

Fig 7.8 Percentage of Professionals Experiencing Difficulty Accessing Other Services for Alcohol Detoxification



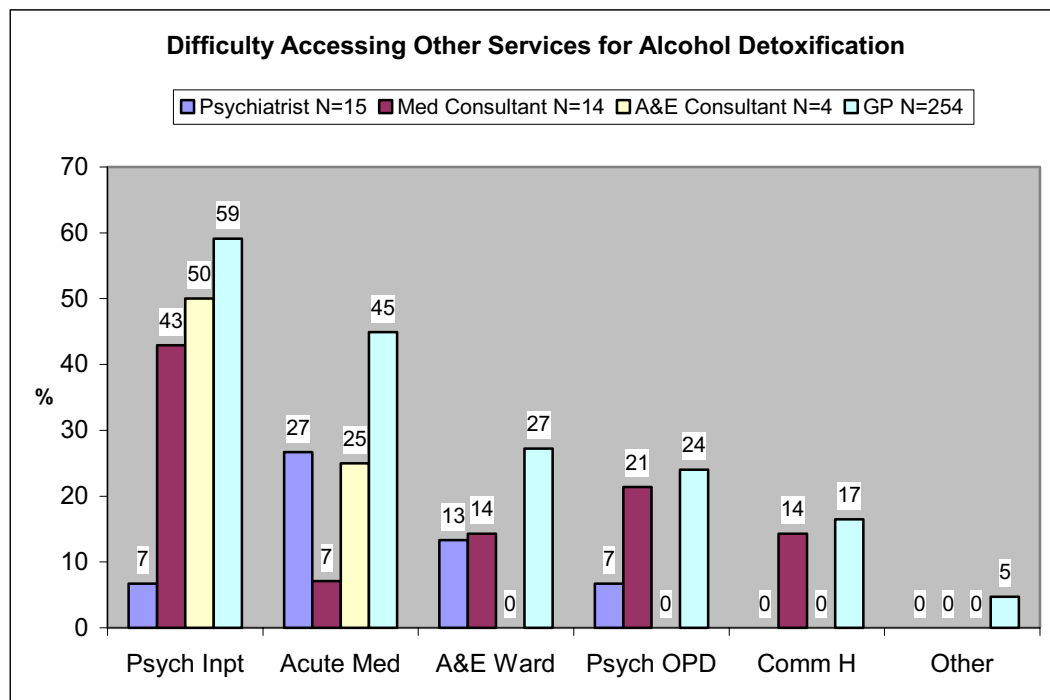
In the comment box asking medical service providers about services accessed for detoxification outside of their own service, the following answers were given in order of frequency:

- (i) Tabor Lodge, Belgooley, Co. Cork (20).
- (ii) Talbot Grove, Castleisland, Co. Kerry (10).
- (iii) Other answers included Arbour House, Bushy Park, Co. Clare, Aiseiri, Cahir St. Patrick's Hospital, Dublin, private hospitals and prison.

7.7.3 Services, which were difficult to access

Respondents were then asked to detail which services they found difficult to access for alcohol detoxification. The highest reported difficulty accessing a service was psychiatric in-patient by all professional groups (except psychiatrists). Please refer to Fig. 7.9.

Fig 7.9 Professional's Difficulty Accessing other Services for Alcohol Detoxification



In the comment box asking about difficulty accessing other services for alcohol detoxification a range of comments were received. Some of the comments included:

- (i) *'Voluntary treatment centres have waiting lists and can be costly for the client'.*
- (ii) *'I believe research shows that most of the above are no more effective than community based service'.*
- (iii) *'No service wasn't to deal with acute detox i.e. every service wants patient off alcohol for 1-2 days'.*

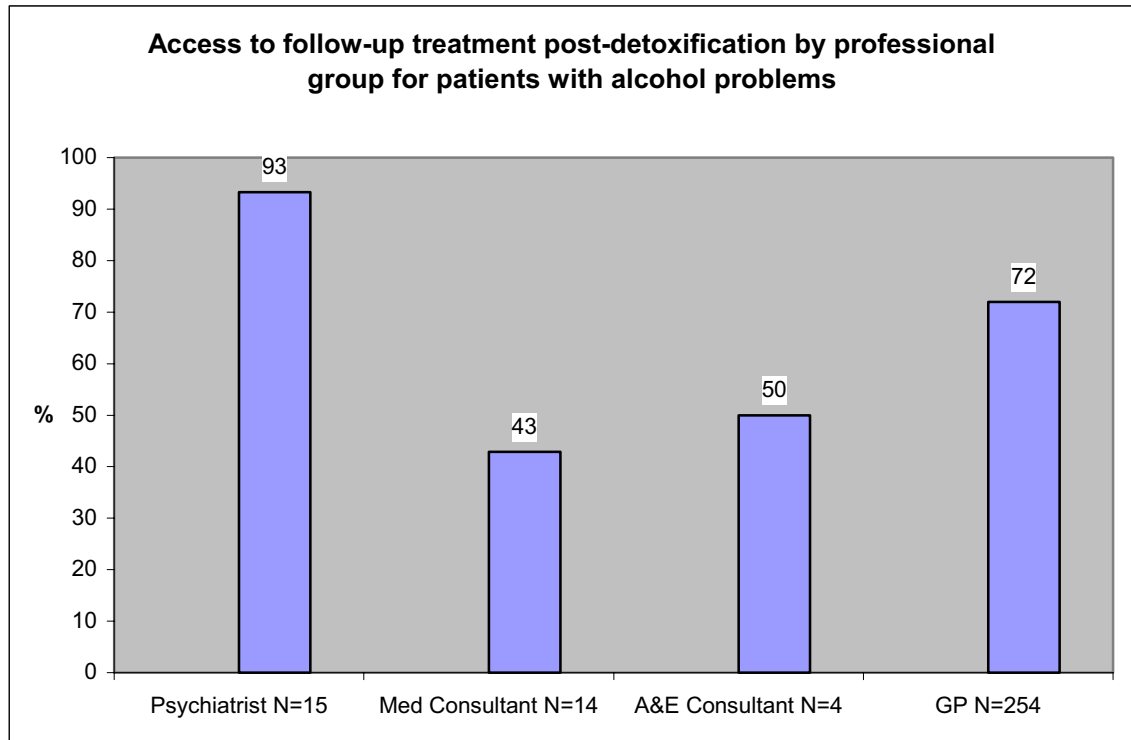
In the comment box asking how access to other services for detoxification could be improved, medical service providers in order of frequency gave the following replies:

- a. Need to increase bed availability for detoxification (4).
- b. Need for a Specialist Detoxification Unit (4).
- c. Need to develop guidelines (3).
- d. Need to clarify which professional is responsible for detoxification (3).
 - (d.i) *'nobody wishes to deal with detoxification. Most can be managed in the community but those that need inpatient care have nowhere to go. Neither psychiatry or medical department wish to treat detoxification. There is no service to access'.*
- e. Other comments included;
 - (e.ii) *'Specialist fast track system geared for such needs'*
 - (e.iii) *'I don't think community hospitals, A&E wards etc. are suitable locations for alcohol detox'.*

7.8 ACCESS TO TREATMENT SERVICE POST DETOXIFICATION

Medical respondents were asked if they had access to follow-up treatment for their patients post-detoxification for alcohol. Overall 71% had access to follow-up treatment for their patients. Fig. 7.10 shows the breakdown by professional group.

Fig 7.10 Access to follow-up treatment post-detoxification by professional group for patients with alcohol problems

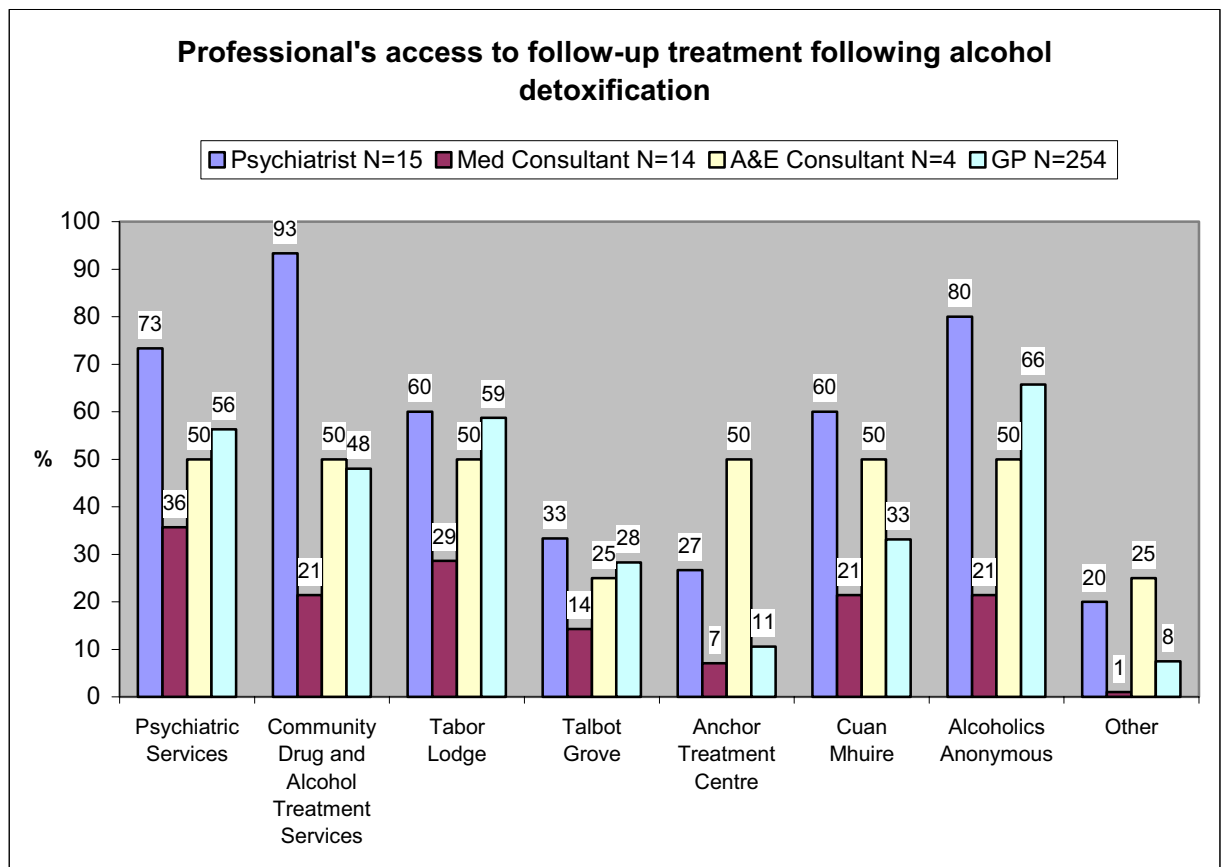


Medical professionals were asked where they accessed follow-up treatment for their patients post alcohol detoxification. Fig 7.11 gives the breakdown by professional group. Psychiatrists were most likely to access post detoxification services either in the community drug and alcohol community counselling services (93%) or through Alcoholics Anonymous (80%). Medical consultants were most likely to access treatment services in the psychiatric services (36%).

Half of Consultants in A&E Medicine said they accessed all of the following: psychiatric services, community drug and alcohol counselling services, Alcoholics Anonymous and Tabor Lodge.

GPs were most likely to access Alcoholics Anonymous (80%) and the psychiatric services (73%).

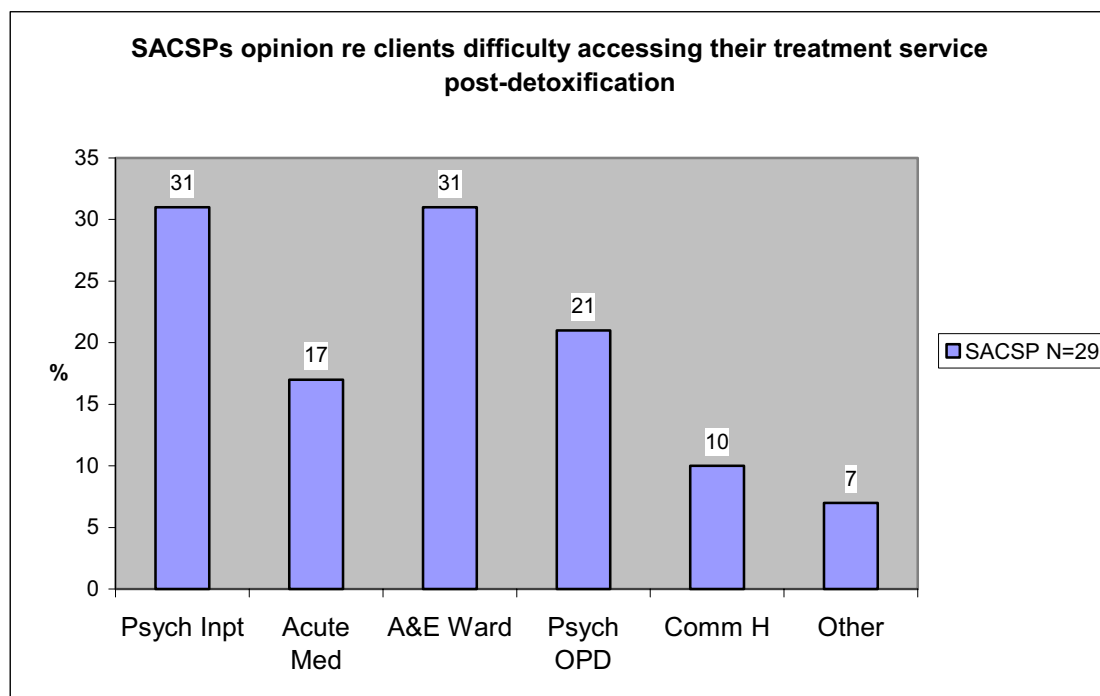
Fig 7.11 Professional's access to follow-up treatment following alcohol detoxification.



SACSPs were asked if they thought that clients who had been detoxified by other services had difficulty accessing their treatment service. 37.9% (11) replied that they thought clients had difficulty accessing the treatment service.

They were then asked to indicate which services the clients might have difficulty accessing their treatment service post-detoxification Fig 7.12. Thirty one per cent said that they thought clients had difficulty accessing their service post detoxification from the psychiatric admission ward and from the A&E ward.

Fig 7.12 SACSPs opinion re client’s difficulty accessing their treatment service post-detoxification.



7.9 SUPERVISION OF DETOXIFICATION FOR DRUGS OTHER THAN ALCOHOL

7.9.1 Medical Respondents

7.9.1.1 Numbers supervising Detoxification for Drugs other than Alcohol

All medical professional groups except A&E consultants reported supervising detoxification for drugs other than alcohol within their own practice setting. This

included 80% of psychiatrists, 30 % and 21% of GPs and medical consultants respectively reported supervision of detoxification for drugs other than alcohol (Fig. 7.13).

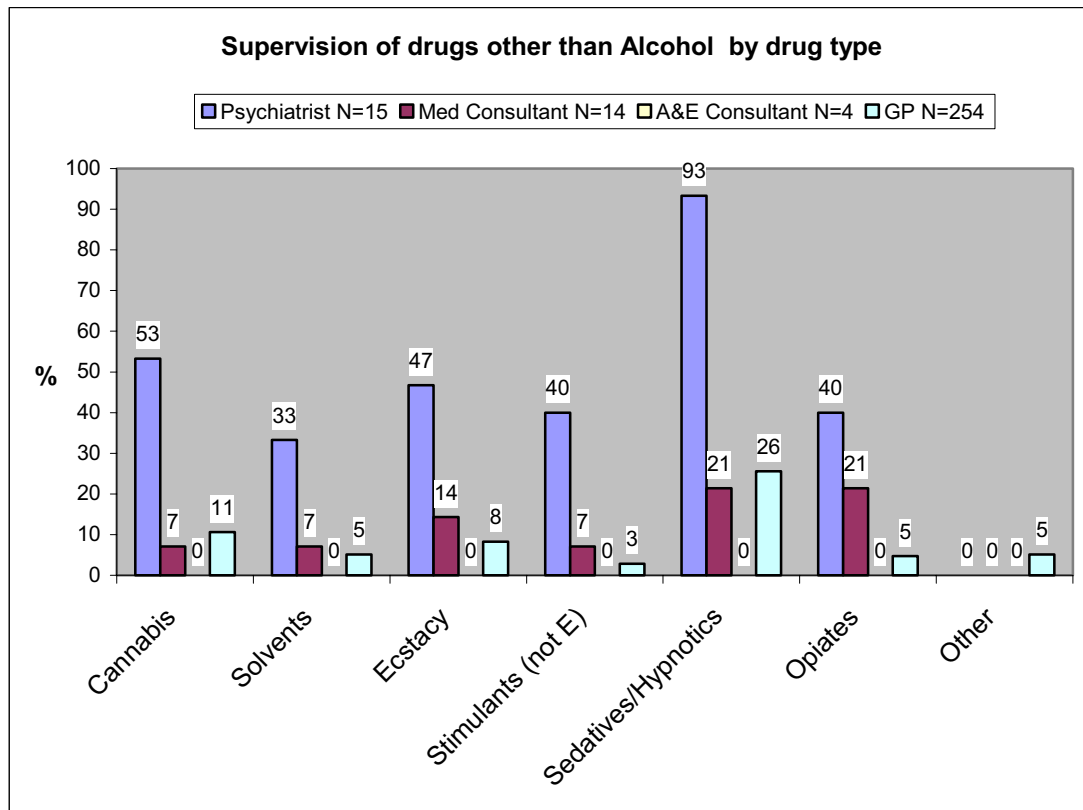
Fig. 7.13 Professional's Supervision of Detoxification for Drugs other than Alcohol.

7.9.1.2 Supervision of Drugs other than Alcohol by drug type

Psychiatrists report the highest levels of supervision for detoxification for all categories of drugs other than alcohol e.g. 93% report detoxification from sedatives/hypnotics. 53% and 47% of psychiatrists respectively outlined detoxification for cannabis and ecstasy.

Among GPs, sedatives and hypnotics were the highest category for detoxification at 26%. Twenty one per cent of medical consultants reported providing detoxification from both opiates and sedatives / hypnotics (Fig. 7.14).

Fig 7.14 Professional’s supervision of drugs other than alcohol within their own practice setting by drug type.



In the comment box asking re supervision for drugs other than alcohol two medical service providers replied that they supervised detoxification from benzodiazepines.

Other comments included:

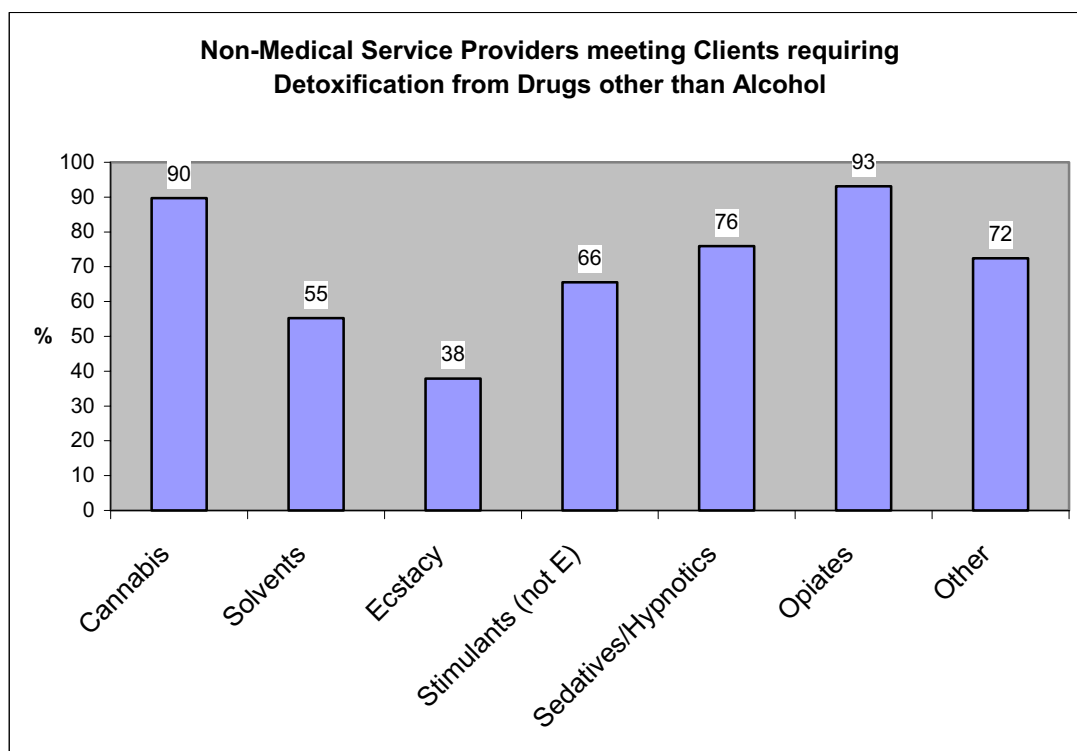
- a. *'all drugs of addiction, benzos, iatrogenic'.*
- b. *'I would not attempt to do so because of lack of back-up facilities'.*
- c. *'No assistance with heroin addicts'.*
- d. *'Abuse of SSRI, antidepressants, prozac'.*

7.9.2 Specialised Addiction Counselling Service Providers

7.9.2.1 Detoxification for Drugs other than Alcohol within their service

Seventy two per cent of specialised addiction counselling service providers said that detoxification for drugs other than alcohol was undertaken within their service. 96% of non - medical service providers reported that they sometimes met clients who needed detoxification from drugs other than alcohol. The highest reported drug groups among the specialised addiction counselling service providers were opiates and cannabis at 93% and 90% respectively (Fig 7.15).

Fig. 7.15 SACSPs meeting clients requiring Detoxification from Drugs other than Alcohol.



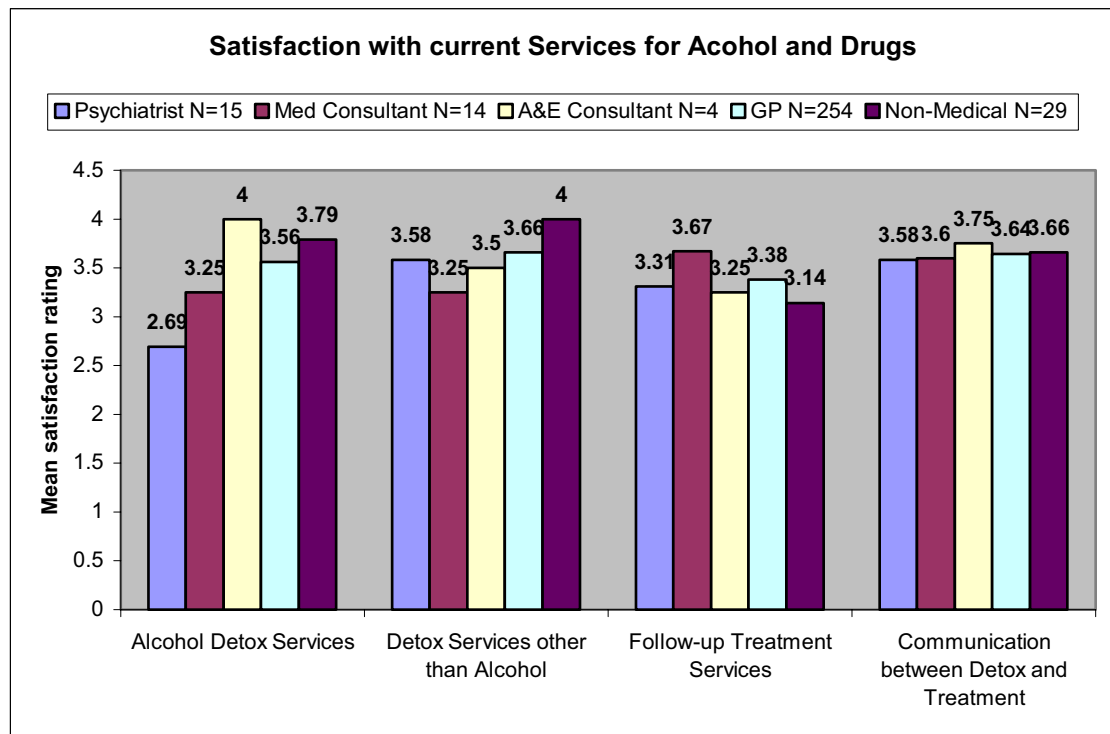
7.10 SATISFACTION LEVELS WITH CURRENT SERVICES FOR DRUGS AND ALCOHOL

Respondents were asked to rate their satisfaction with various aspects of the services for alcohol and drugs. Fig. 4.13 shows a breakdown of the results (Note that 1 = very satisfied, 2 = satisfied, 3 = neither, 4 = dissatisfied, 5 = very dissatisfied, therefore results of > 3 show a tendency towards dissatisfaction). The mean scores for satisfaction for all professionals (except psychiatrists) were

greater than three indicating dissatisfaction with current alcohol detoxification services.

The mean score for psychiatrists was 2.69, which indicates that psychiatrists are more satisfied than the other professional groups. For the remaining areas (satisfaction with detoxification services for drugs other than alcohol, satisfaction with follow – up treatment services following detoxification for alcohol and drugs and for satisfaction with level of communication between detoxification and addiction treatment services), all scores in all professional groups were more than three, again indicating an underlying dissatisfaction with these services.

Fig. 7.16 Professional’s Satisfaction with current Services for Alcohol and Drugs



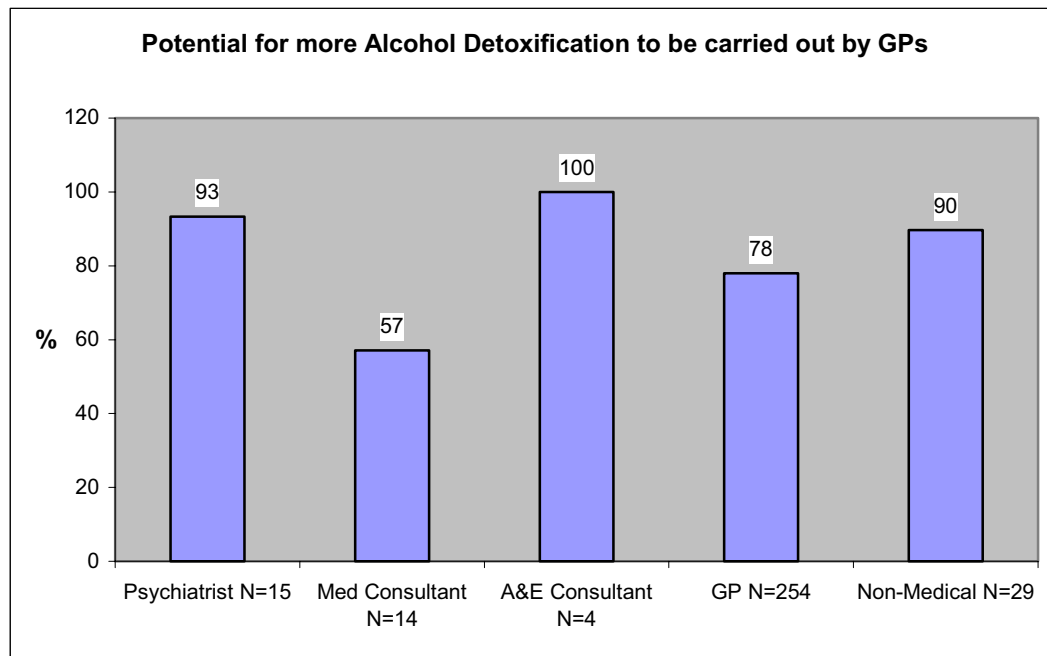
In the comment box following the satisfaction-rating question, the following comments were made in order of frequency:

- a. Poor communication between services (3).
- b. Poor co-ordination of services (3).
- c. More liaison needed (3).
- d. Other comments included;
 - (d.i) *‘Really the services don’t advertise themselves or their programme or their availability very well’.*
 - (d.ii) *‘No support for families or GPs’.*
 - (d.iii) *It is not uncommon for those who detoxify in acute situation to be lost to follow-up’.*

7.11 POTENTIAL FOR MORE DETOXIFICATION TO BE CARRIED OUT BY GPS

The majority of all service provider groups including GPs themselves (78%) expressed the view that there was a potential for more alcohol detoxification to be carried out by GPs. Fig 7.17 shows the breakdown by professional group.

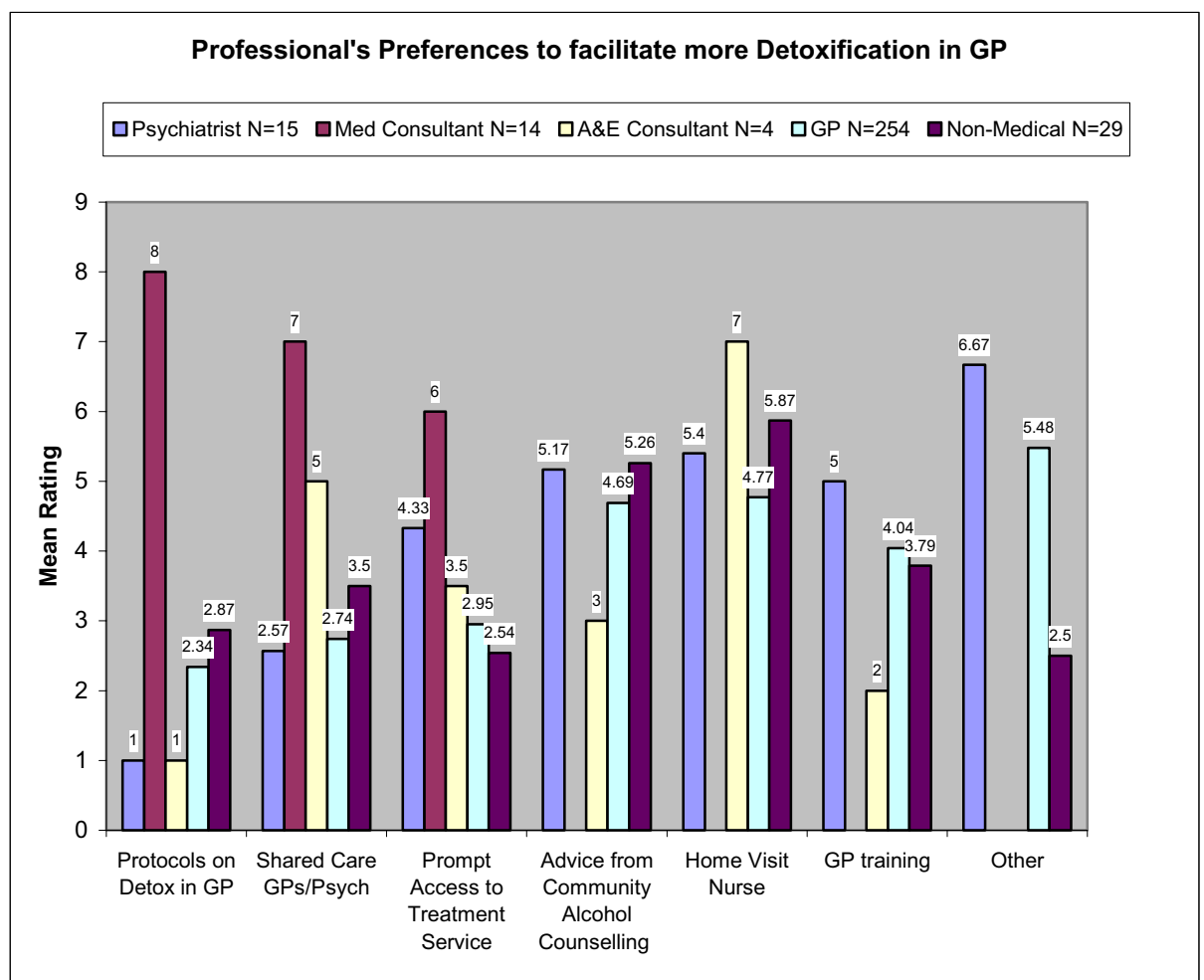
Fig. 7.17 Potential for more Alcohol Detoxification to be carried out by GPs.



Respondents were asked to rank in order of importance (1 = most important, 8 = least important) a number of statements in relation to potential for more detoxification for alcohol to be carried out by GPs.

Fig 7.18 shows the breakdown of mean score for each statement. GPs and psychiatrists gave highest priority to protocols on detoxification within general practice followed by shared care between GPs and Psychiatry in relation to detoxification. Non - medical professionals selected protocols in detoxification in general practice followed jointly by prompt access to treatment services post - detoxification and other options.

Fig. 7.18 Professional's Preferences to facilitate more Detoxification in GP.



In the comment box asking if there was potential for more detoxification to be carried out by GPs, the following comments were made:

- a. Funding for detoxification by GPs (3)
- b. Education for professionals (2)
- c. Other comments included;

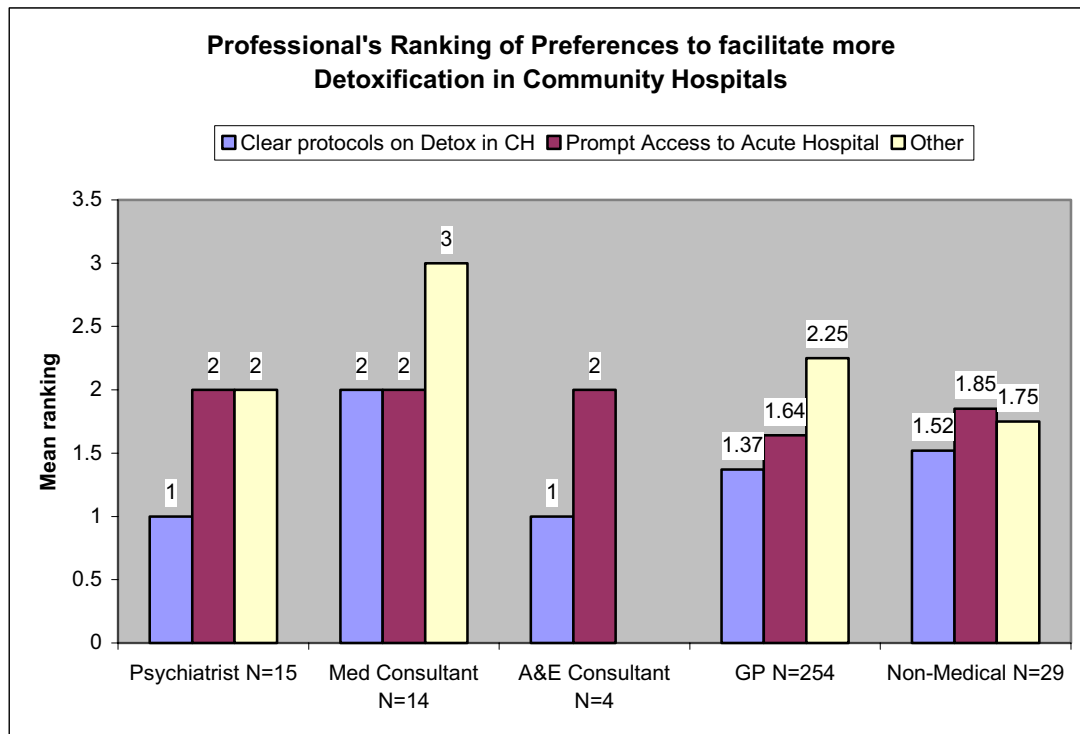
(c.i) *'Someone to visit the home and supervise house situation'*

(c.ii) *'Every GP should be in the game of detox. Any GP who cannot deal with it is basically close to useless at his job. Detox is a necessity of a GPs world. It's like treating toothache by a dentist'*

(c.iii) *'Prompt access to treatment services post detox'*.

With regard to the potential for more detoxification to be carried out in community hospitals, respondents were asked to rank three options (1 = most important, 3 = least important). GPs supported clear protocols on detoxification for community hospitals/GPs followed by prompt access to an acute hospital facility as necessary. Fig. 7.19 indicates the breakdown of preferences by professional group.

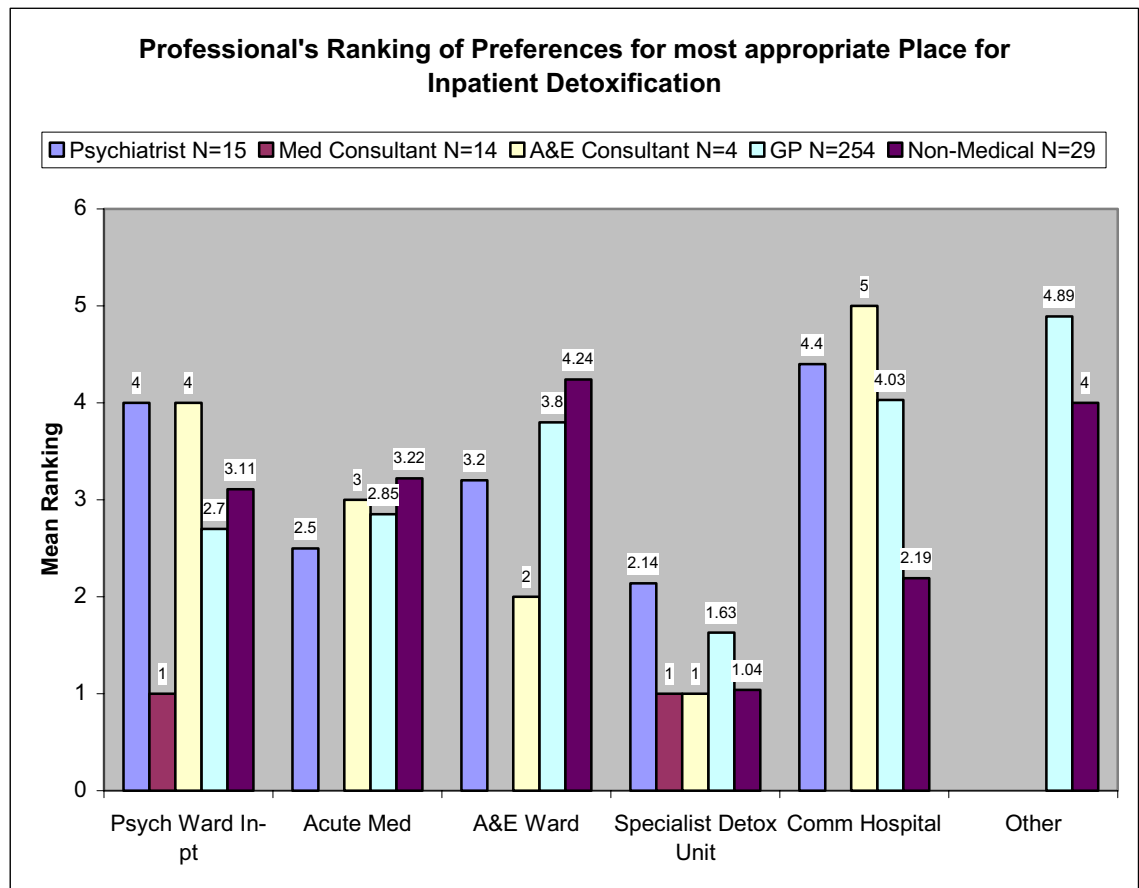
Fig 7.19 Professional's Ranking of Preferences to facilitate more Detoxification in Community Hospitals.



7.12 MOST APPROPRIATE PLACE FOR INPATIENT DETOXIFICATION

Respondents were asked to rank where they thought was the most appropriate place for inpatient alcohol detoxification (1 = most important, 6 = least important). The highest ranking for all professional groups was given to a Specialist Detoxification Unit. Fig.7.20 gives a breakdown of results by professional group.

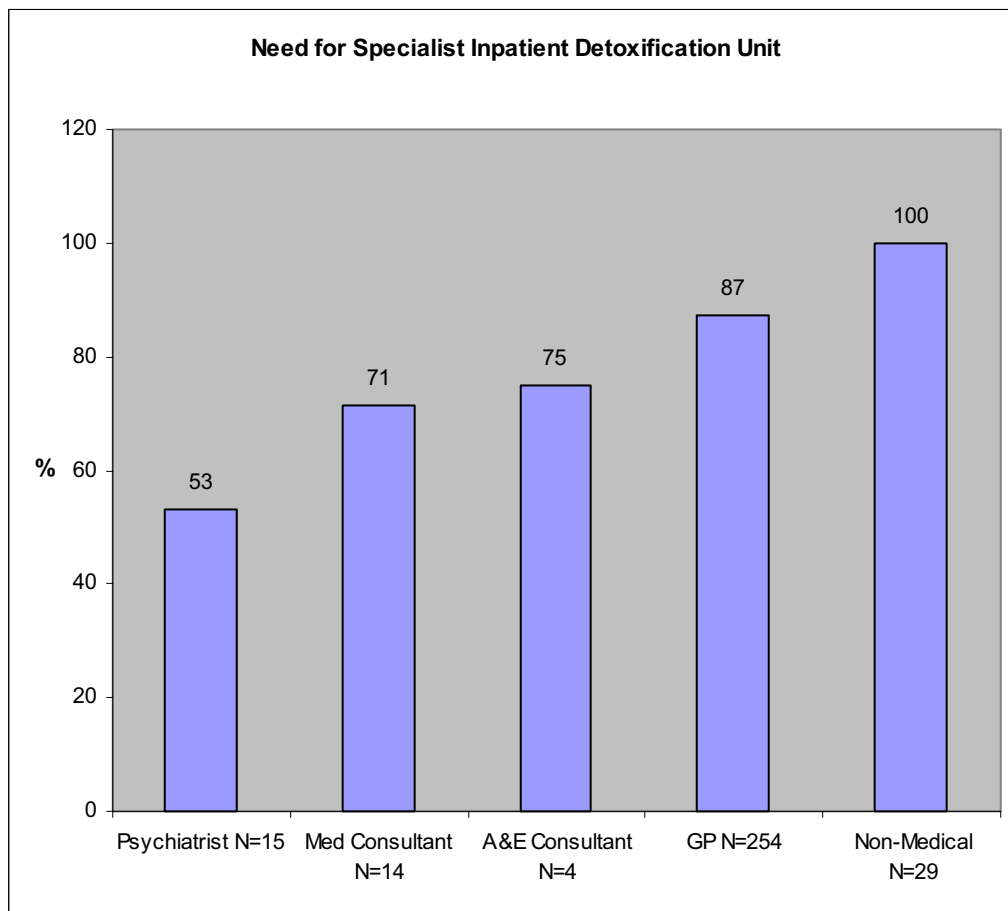
Fig 7.12 Professional's ranking of preferences for most appropriate place for inpatient detoxification.



7.13 SPECIALIST INPATIENT DETOXIFICATION UNIT

The majority of all professional groups also expressed the need for a Specialist Inpatient Detoxification Unit. One hundred per cent of non - medical professionals were in favour compared with 53% of psychiatrists (Fig. 7.21).

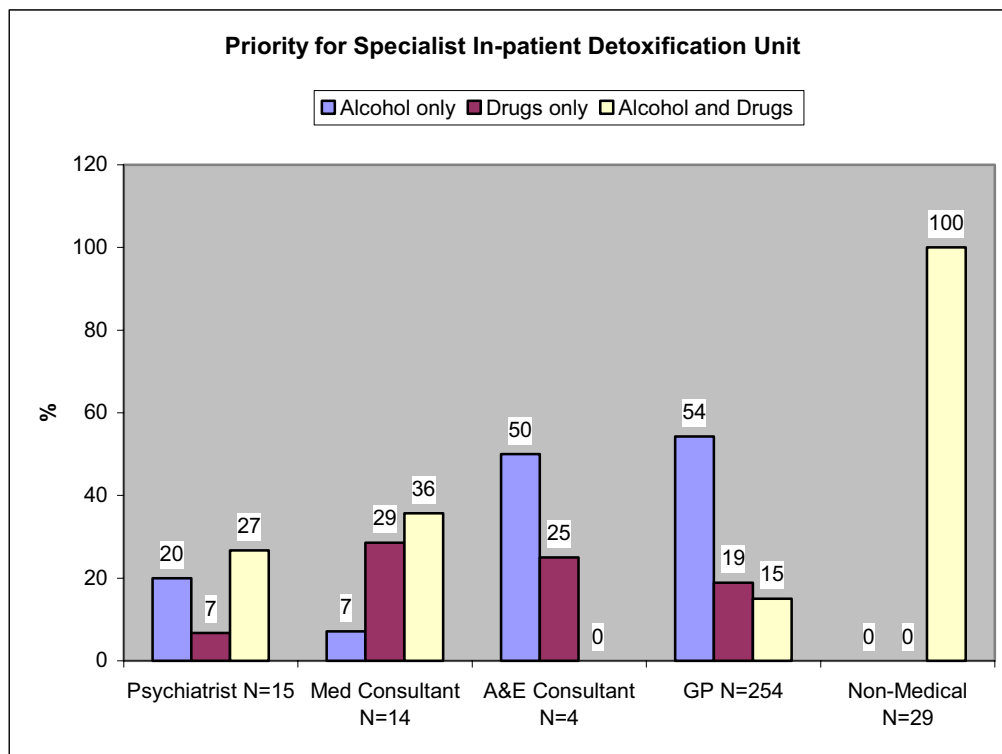
Fig. 7.21 Professional's View on Need for Specialist Inpatient Detoxification Unit.



7.13.1 Type of Specialist Inpatient Detoxification Unit

Respondents were asked to prioritise the type of specialist inpatient detoxification unit that they would favour i.e. a unit for alcohol alone, drugs alone or a unit for both alcohol and drugs. One hundred per cent of non - medical service providers favoured a unit for both alcohol and drugs. Medical service providers had more mixed views; 54% of GPs and 50% of Consultants in Accident and Emergency expressed a preference for a unit for alcohol alone. Thirty six per cent of Medical Consultants and 27% of Psychiatrists supported a unit for both alcohol and drugs (Fig 7.22).

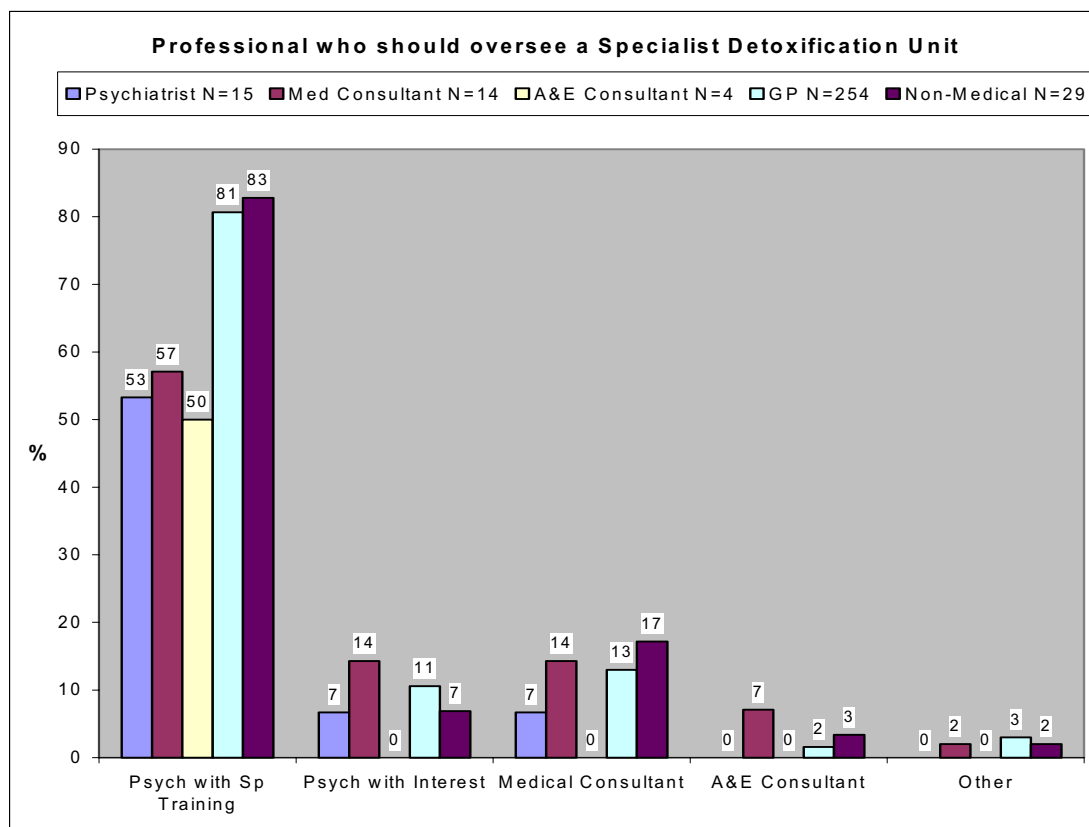
Fig. 7.22 Professional's Priority for Specialist In -patient Detoxification Unit.



7.13.2 Professional who should oversee a Specialist Detoxification Unit

Respondents were asked which professional should oversee a specialist detoxification unit. The majority in all professional groups favoured a psychiatrist with special training in addiction (Fig. 7.23)

Fig. 7.23 Professional who should oversee a Specialist Detoxification Unit.



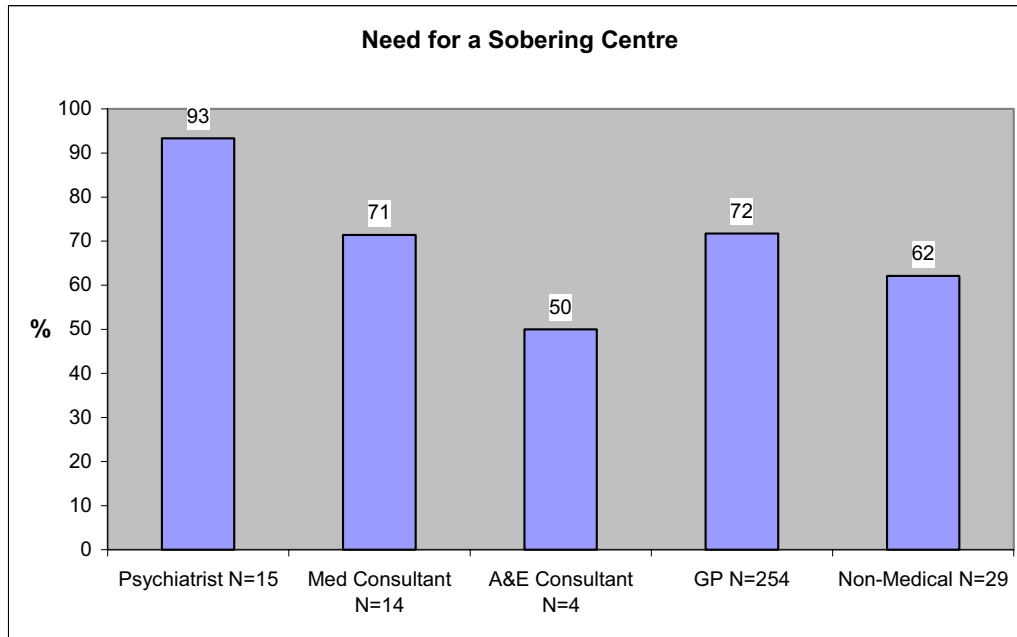
In the comment box regarding who should oversee a specialist detoxification unit there were 3 replies that a GP or group of GPs with a special interest should oversee such a unit. Two replied that a medical consultant with special training could oversee this unit. Two respondents said that a multidisciplinary team should oversee the unit.

7.14 SOBERING CENTRE

Sobering centres were defined in the questionnaire as 'places where people who are drunk are allowed to sleep overnight and are assessed the following day for further detoxification or treatment or discharge'. Seventy two per cent overall in

the professional groups favoured a sobering centre with psychiatrists having the highest favourable response at 93%. Fifty per cent of Consultants in Accident and Emergency were in favour (Fig 7.24).

Fig. 7.24 Need for a Sobering Centre.



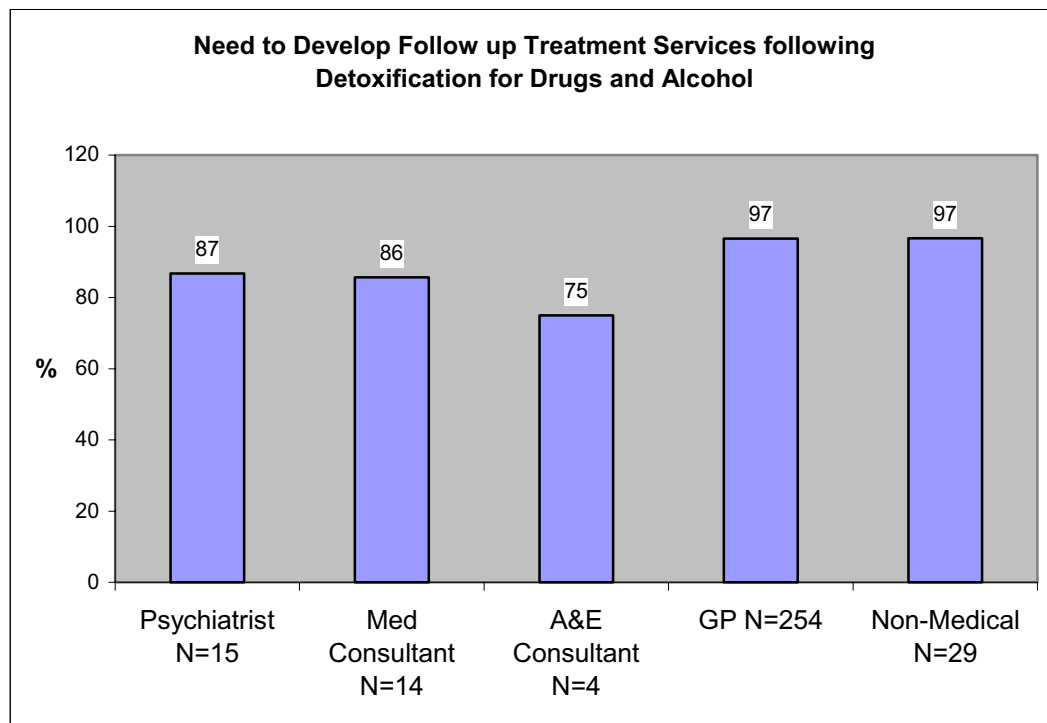
In the comment box following the question on provision of sobering centre in the Region the following comments were received in order of frequency:

- a. In favour of such a unit (14).
- b. Potential for abuse of sobering centre (8).
 - (b.i) *e.g. 'This service would be open to an enormous amount of abuse'.*
- c. In favour of sobering centre but with a qualification (10).
 - (c.i) *e.g. 'with proper security it sounds like a good idea'.*
- d. Not in favour (6).
- e. Respondents suggested that patients should be billed for the service they would receive in a sobering centre (6).
- f. Other comments included:
 - (f.i) *'Psychiatric units often being used as drunk tanks, totally inappropriate, with claims of suicidal ideation being the lever for admission and patient discharging themselves the following day'.*
 - (f.ii) *'Need supervision, risks involved e.g. inhaled vomit, missed head injury in patient who has fallen'.*

7.15 FOLLOW-UP TREATMENT SERVICES FOLLOWING DETOXIFICATION

Overall 96.5% of all professional groups were in favour of developing the follow-up treatment services for alcohol and drugs. Fig. 7.25 gives a breakdown by profession.

Fig. 7.25 Need to Develop Follow up Treatment Services following Detoxification for Drugs and Alcohol.



In the comment box on this question, the following are examples of the comments received:

- a. Three SACSP were in favour of developing an Anchor Treatment Centre in Mallow

Other comments included:

- b. *'Addiction counsellors assigned to a group of GPs in an area'*.
- c. *'Needs immediate transfer from detox to a counsellor'*.
- d. *'Half-way house, staff evaluation'*.

7.15.1 Professional's Ranking of Preferences for the Future Development of Treatment Services for Drugs and Alcohol

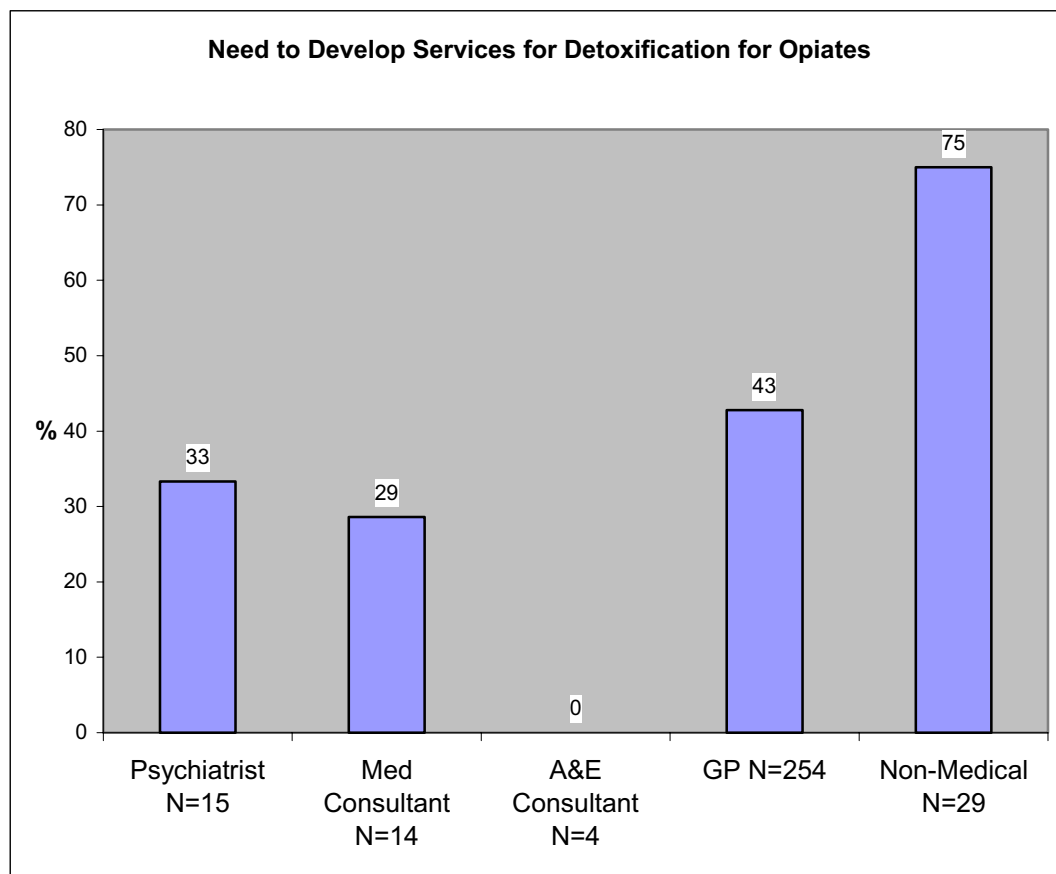
Respondents were asked to rank in order of importance possible options for development of follow - up treatment service for alcohol and drugs (1 = most important, 7 = least important). Psychiatrists, GPs and Specialised Addiction Counselling Service Providers on average gave first preference to addiction counsellors jointly appointed between detoxification services and current community based drug and alcohol treatment services. Fig 7.24 gives a detailed breakdown by profession of the expressed preferences.

Fig. 7.26 Professional's Preferences re future Development of Treatment Services for Drugs and Alcohol.

7.16 DETOXIFICATION SERVICES FOR DRUGS OTHER THAN OPIATES

Only 41.5% of all respondents were in favour of developing a detoxification service for opiates. However, 75% of Specialised Addiction Counselling Service Provider respondents were in favour of developing a service (Fig 7.27)

Fig. 7.27 Need to Develop Services for Detoxification for Opiates.



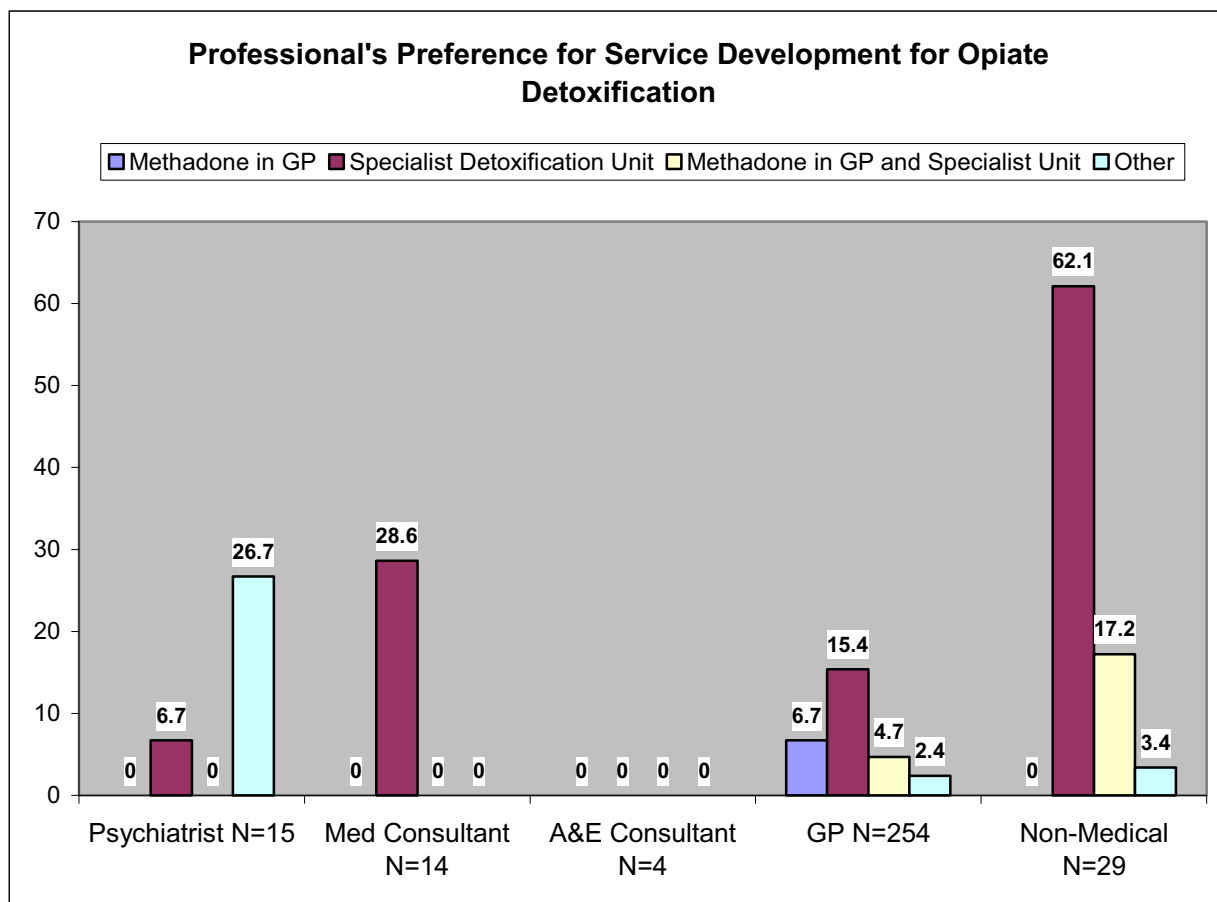
7.16.1 Professional's Preference for Service Development for Opiate Detoxification

Respondents were given four preferences for developing detoxification services for opiates. The options were: developing detoxification using methadone within a GP setting, detoxification within a specialist unit, a combination of both a specialist unit and using methadone in GP or to suggest another option different to the previous three.

The option that received most support was the specialist unit with 62% of Specialised Addiction Counselling Service Providers favouring this choice. It has

less support among the medical groups with only 29% of medical consultants, 15% of GPs and 7% of psychiatrists in favour (Fig 7.28).

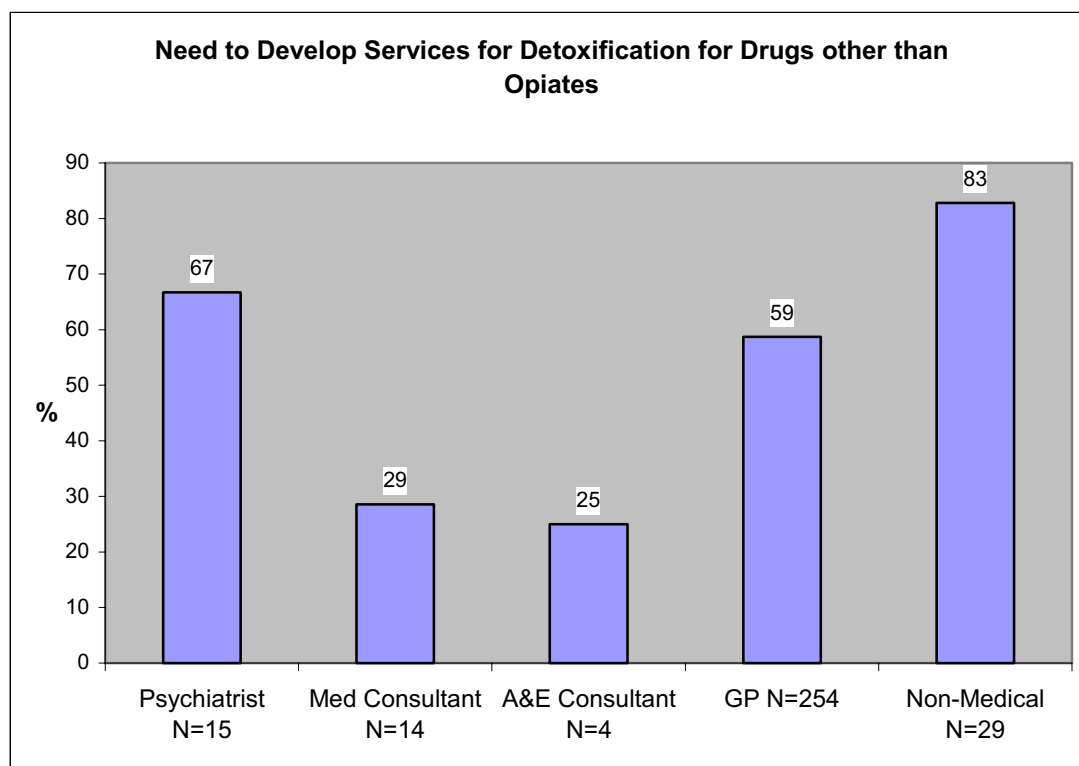
Fig. 7.28 Professional's Preference for Service Development for Opiate Detoxification.



7.17 DETOXIFICATION SERVICES FOR DRUGS OTHER THAN OPIATES

Overall, 60% of respondents were in favour of developing services for detoxification for drugs other than opiates. 83% of non - medical personnel and 67% of psychiatrists expressed this preference (Fig 7.29).

Fig. 7.29 Need to Develop Services for Detoxification for Drugs other than Opiates.



In the comment box regarding the need to develop services for detoxification other than opiates the following comments were received in order of frequency:

- a. The need to develop an in-patient detoxification unit and increase the number of community counsellors (14).
- b. The need to develop general practice and specialist in-patient services (10).
- c. The need to develop in-patient psychiatric services (10).
- d. The need to develop community based counsellors (7).
- e. The need for a specialist in-patient detoxification unit (5).

Respondents were asked to comment on areas of unidentified need in relation to detoxification services for drugs and alcohol that needed to be addressed. The following areas were identified in order of frequency:

- f. The need for rapid access to a detoxification service (18).
- g. The need for a detoxification unit and co-ordinated services post detoxification (18).
- h. Current detoxification needs are not being met (8).
- i. The need to develop services for adolescents (7).
- j. The need for public education (8).
- k. The need for education for GPs (5).
- l. The need for a specialist detoxification unit (4).
- m. The need for primary prevention.
- n. Other responses included:
 - (n.i) *'This questionnaire is an admission of the major needs'.*

Respondents were also asked if there was anything else they would like to add on the topic of detoxification for drugs or alcohol. The following comments were made in order of frequency:

- o. The need for public education campaigns (7).
- p. The need for more funding (5).
- q. The need to improve multidisciplinary communication/co-ordination (5).
- r. The need for change in legislation i.e licensing laws or ban on sports advertising (3).
- s. Need for a detoxification unit (2).
- t. Other comments included:
 - (t.i) *'Follow-up is poor. Arbour House service is good but needs to be expanded to make it more available'.*
 - (t.ii) *'Treating alcoholism in general practice is one of the most frustrating and unrewarding tasks that GPs face.....I would imagine after 20 years experience that less than one in four change their ways- the remainder continue to make their spouses, families and GPs lives miserable! Nothing will change until Irish society adopt a far more prohibitive attitude to this problem which is a huge burden on the health services and society'.*
 - (t.iii) *'Follow-up treatment for clients who present to hospitals or GPs with alcohol/drug related problems'.*

CHAPTER EIGHT DISCUSSION

8.1 INTRODUCTION

The overall aim of the study was to estimate the need for alcohol and drug detoxification services in Cork and Kerry. This was the first health care needs assessment for drug and alcohol detoxification, which has been conducted in Ireland.

8.2 RESPONSE RATE

The overall response rate was 62%. The response rate varied by profession. The highest response rate was 100% of consultants in A&E medicine. SACSPs and medical consultants also had a high response rate at 81% and 74% respectively. The GP response rate was 60%. This compares well with response rates from other GP surveys[92]. Psychiatrists had the lowest response rate at 50%. However, psychiatrists were well represented in the qualitative research and six had been interviewed.

8.3 RESULTS OF EPIDEMIOLOGICAL AND COMPARATIVE NEEDS ASSESSMENT

8.3.1 Demand Based Approach to Needs Assessment

There are two broad approaches to needs assessment. The majority of needs assessments use a demand based approach[93], that is service needs are projected on the basis of past patterns of use of the treatment service.

In this needs assessment, the results show a large increase in demand for treatment services for alcohol particularly with a 40% increase HIPE discharges for the years reviewed (1999) and a three fold increase from 602 to 1778 on the NTDRS data. In 62% of cases alcohol was the main substance of misuse. There is a lack of information of how many of these treatment episodes require detoxification but it is likely that these increases reflect a corresponding increase in demand for detoxification for alcohol particularly.

The main limitation of this approach is that it does not specify how things ought to be but merely reflects how things are.

8.3.2 Systems Based Approach to Needs Assessment

A systems based approach projects services on the basis of what should be in place rather than what currently exists. The 'Rush'[82] model is one such approach. Using UK data an estimate of 611 places for detoxification in a year was obtained. However, it is unclear from this model whether this relates specifically to those who would require inpatient detoxification or both inpatient and community based detoxification.

8.4 RESULTS OF CORPORATE NEEDS ASSESSMENT: QUALITATIVE AND QUANTITATIVE

Because the results of the qualitative study and the quantitative study show many similar results, the results will be presented for each section qualitative then quantitative where possible.

8.4.1 Detoxification for Alcohol

Qualitative

HSPs had wide experience of personally providing detoxification for alcohol. Consultants dealt with higher numbers than GPs.

Quantitative

Sixty two per cent of all medical professionals in the survey undertook detoxification for alcohol within their own practice setting. The estimated mean number of patients detoxified within the past year was 33 for psychiatrists and six for GPs. This indicates psychiatrists have the greatest experience but because of the much larger numbers of GPs, the largest numbers of detoxification takes place in general practice. It also indicates the potential for carrying out more detoxification in the community supervised by GPs.

Quantitative

The setting in which medical respondents said that they undertook detoxification for alcohol in the main coincided with their own practice setting. Almost 60% of GPs provided detoxification to clients in the community.

It is of interest that community hospitals are currently little used for alcohol detoxification e.g. 4% of GPs.

Seventy nine per cent of Specialised Addiction Counselling Service Providers respondents said that detoxification for alcohol occurred within their service. In the majority of cases, the service was provided by GPs, either GPs working specifically within the treatment service or the client's usual GP. Again, this shows the potential for utilising GP services.

8.4.2 Access to Services outside their own service for Alcohol Detoxification

Quantitative

Almost three quarters of all service providers (medical and non-medical) sometimes accessed alcohol detoxification services outside their own service. These were mostly hospital services with the exception of Cuain Mhuire in Bruree which was accessed by a high percentage of GPs and Specialised Addiction Counselling Service Providers.

Overall 65% of respondents said they had difficulty accessing services outside their own for alcohol detoxification. The highest reported difficulty accessing other services for alcohol detoxification was psychiatric in-patient by all non-psychiatric professional groups.

8.4.3 Supervision of Detoxification for Drugs other than Alcohol

Qualitative

HSPs, generally, had experience of carrying out detoxification for drugs other than alcohol. Some psychiatrists provide opiate detoxification with methadone. Of drugs other than opiates, benzodiazepines emerged as a problem, which required detoxification.

Quantitative

A different pattern was shown among professional groups carrying out detoxification for drugs other than alcohol. There was a disparity among medical groups with 80% of psychiatrists supervising detoxification compared to only 30% of GPs. This contrast showed 62% overall who engaged in alcohol detoxification. Psychiatrists most experienced for almost all groups of drugs and GPs had least involvement in detoxification for all drug groups exceptedatives/hypnotics (26%).

After alcohol sedatives/hypnotics the most common group seen by medical professionals for detoxification.

Specialised Addiction Counselling Service Provider respondents said that they sometimes met clients who needed detoxification for drugs other than alcohol within their service. The highest reported drug groups were opiates and cannabis.

8.4.4 Satisfaction Levels

Quantitative

Almost all professional groups showed satisfaction with the spectrum of services for alcohol and drugs. Only psychiatrists were satisfied with current alcohol detoxification.

8.4.5 Potential for more Detoxification to be carried out by GPs

Qualitative

More detoxification could be carried out in general practice if the types of support that would be necessary included training for GPs, a professional support system e.g. under the supervision of a specialist services or a community addiction team.

Quantitative

The majority of all service providers including GPs saw a potential for alcohol detoxification to be carried out by GPs. Protocols in general practice was the highest-ranking factor, which would facilitate more detoxification in general practice. There is a body of literature which says that out-patient detoxification is safe and clinically effective for patients with mild to moderate alcohol withdrawal [12, 47, 94].

8.4.6 Potential for more Detoxification in Community Hospitals

Qualitative

Community Hospitals could have a role in detoxification but reservations were expressed re ensuring staff safety and the need to avoid having a patient with delirium tremens in a community hospital setting.

Quantitative

While the majority of professional groups said that more detoxification should be carried out in community hospitals, it is interesting to note that GPs were more cautious about doing more detoxification in a community hospital setting.

All professionals favoured clear protocols on detoxification in community hospitals as the issue most likely to facilitate more detoxification in community hospitals.

8.4.7 Specialist Detoxification Unit

Qualitative

HSPs see a need for a psychiatrist who specialises in drugs and alcohol in the region. A specialist inpatient detoxification unit also emerged as an issue. Small units for detoxification for those areas distant from Cork city would be more practical.

Quantitative

All professional groups ranked the concept of a specialist detoxification unit as the most appropriate place for in-patient detoxification. The majority of all professional groups saw a need for a specialist inpatient detoxification unit in the SHB. The views on the type of unit (i.e. for alcohol alone, drugs alone or for drugs and alcohol) were mixed with non-medical clearly favouring a unit for both drugs and alcohol. The majority in all professional groups thought that a psychiatrist with special training in addiction should oversee a specialist unit.

8.4.8 Sobering Centres

Qualitative

It is very difficult to access detoxification services for the homeless currently.

Quantitative

All professional groups were in favour of developing a sobering centre. However, the issues around sobering centres are complex and need to be explored carefully. This includes, particularly, the need to develop safe protocols to ensure that clients with medical complications are referred appropriately for specialist care [55]. While sobering centres may offer a service for clients who are not homeless in some instances, overall, the provision of an accessible detoxification service for homeless people with drug and alcohol problems is important. There is no evidence of the effectiveness of one type of model over another (e.g. wet houses versus sobering centre) for homeless people. However,

Cook's model outlines the need to provide services for the homeless as part of an integrated response to alcohol misuse[15].

8.4.9 Need to develop follow-up Treatment Services following Detoxification for Drugs and Alcohol

Qualitative

Liaison workers and guidelines/protocols between services emerged as solutions for integrating the service.

Quantitative

All professional groups were in favour of developing the follow-up treatment services post detoxification for drugs and alcohol. This clearly recognises the importance of links from the detoxification services to the treatment phase.

All groups (except Consultants in Accident and Emergency Medicine) gave first preference to counsellors jointly appointed between the detoxification services and current community based treatment services. This also emphasises the links to National Treatment Agency's Models of Care [13]

This would give support to the concept of a liaison/link addiction counsellor service.

8.4.10 Development of Detoxification Services Opiates

Qualitative

Mixed views were expressed re the development of detoxification services for opiates. Those against cited the possible increase in the number of heroin addicts if a service was made available and the problems of methadone services elsewhere.

Quantitative

Seventy five per cent of Specialised Addiction Counselling Service Provider respondents were in favour of developing a service for opiates (only 41.5% of respondents overall were in favour). Most favoured a specialist unit as the option to develop detoxification services for opiates. From the previous section regarding opiate detoxification (8.4.4), psychiatrists would appear to have the most experience currently.

8.4.11 Development of Detoxification Services for Drugs other than Opiates

Quantitative

Overall 60% were in favour of developing a detoxification service for drugs other than opiates.

8.4.12 Health Service Users- Qualitative Results

Health service users found detoxification accessible in the community from GPs. Hospital inpatient detoxification was also accessible to them although they did recognise, particularly, that other health service users had difficulties. One client who also suffered from manic depression raised the issue about clients with dual diagnosis needing priority for admission. They thought that extra inpatient beds should be made available for detoxification. A separate unit was suggested as a more appropriate place for detoxification than a psychiatric ward.

8.5 STRENGTHS OF THE STUDY

This study was the first needs assessment for detoxification services for drug and alcohol in Ireland. Epidemiological, corporate and comparative data were used. It is important to take the views of all stakeholders into account when services are being developed. This study was inclusive in that it involved key people such as service users and service providers from community, hospital and specialist addiction counselling service providers. The concordance of findings of both qualitative and quantitative research adds further weight to the validity of the study results.

8.6 WEAKNESSES OF THE STUDY

The major limitation in this needs assessment was the lack of routine information on detoxification. Another limitation was the lack of data of the 'in need' population. This was shown in the estimation using the Rush model for estimating needs for alcohol services. UK data were used, as Irish data was not available. However, in the current year the repeat prevalence survey on drug and alcohol use in Cork and Kerry carried out by the Department of Public Health in 2004 will allow this data to be estimated but this data was not available at time of writing. Similarly, information was not available for Cork and Kerry on estimates for indirect methods of calculating opiate misuse such as capture/recapture methods and multiplier nomination method.

CHAPTER NINE CONCLUSIONS AND RECOMMENDATIONS

9.1 CONCLUSIONS

1. Demand for drug and alcohol (particularly alcohol) treatment services is rising in Cork and Kerry.
2. Current services for alcohol detoxification are fragmented and difficult for most health service providers to access for their patients.
3. There is poor liaison between different elements of the service and a multi-disciplinary team approach is not in place.
4. Services for opiate detoxification with commencement on methadone are not in place.
5. Current best practice according to international models of care is that primary care should be the main setting for treatment with specialist care used selectively. Services should also be planned with a maximum of integration.
6. GPs in Cork and Kerry recognise and are willing to take a central role in detoxification given adequate support.
7. There is no cohesive framework for the development of drug and alcohol treatment services in Ireland.

9.2 RECOMMENDATIONS

The SHB Drug and Alcohol Committee commissioned this report.

The structures in the health service have changed since the report was completed and the Drug and Alcohol Committee are no longer in place.

1. It is recommended that a Drug and Alcohol Detoxification Implementation Committee be established in order to;
 - a. Develop an implementation plan.
 - b. Allocate resources.
 - c. Oversee the recommendations of this needs assessment.
 - d. Monitor and evaluate changes to the service as a result of this needs assessment.

2. Relevant key stakeholders should be invited to participate in this committee including representatives from all the relevant professional groups statutory and voluntary, health service managers, and health service users.

3. Community alcohol detoxification services should be expanded in the Region.
 - a. Primary care should be the main setting for detoxification
 - b. GPs should be given appropriate support and training.
 - c. Home detoxification services should be developed. This requires:
 - (i) The use of agreed detoxification protocols within general practice.
 - (ii) The development of close liaison and guidelines with the addiction/psychiatric services allowing for shared care of more complex cases.

4. Beds should be provided for alcohol detoxification by GPs in the community. Initially, this should be done on a pilot basis in a couple of different areas and evaluated. If found to be effective, the scheme can be extended throughout the region.

Options to be explored for further extra beds would include;

- a. Potential for use of voluntary residential treatment services where appropriate.
- b. Contracting beds specifically for detoxification within a private hospital.

- c. Potential use of community hospitals in some circumstances e.g. as a step-down facility for patients who have been hospitalised in an acute medical ward for medical complications and also require detoxification. This may need to be part of a broader review of the role of community hospitals.
 - d. The clinical responsibility for the patients who use these beds should be with the general practitioner.
- 5. Specialist in-patient beds for detoxification from alcohol and other drugs.
 - a. Beds should be designated/contracted in the current psychiatric/medical services specifically for in-patient detoxification of more complex cases.
 - b. In the future, this model could form the basis of developing specialist detoxification services for substance misuse.
- 6. Development of specialist services for detoxification
 - a. A multidisciplinary team including a specialist psychiatrist should be designated for alcohol/substance misuse
 - b. These staff should form the Substance Misuse Detoxification Team (SMDT).
 - c. SMDT to provide specialist inpatient detoxification and support to GPs for outpatient detoxification and liaison with community based addiction treatment services.
- 7. Link Counsellors
 - a. There is a need to develop the role of Link Counsellors. Link counsellors will be employed by the current community counselling services, but will have a significant time commitment to linking with detoxification services, and providing onsite counselling as necessary.
 - b. These will act as a link between the varied settings of detoxification services and current community treatment services. They will provide linkages to the treatment services both statutory and voluntary and should work between detoxification and treatment services.

- c. Link Counsellors should be targeted to the varied settings of detoxification i.e. general practice, psychiatric services, medical and A&E services. The link counsellors in primary care settings should provide on-site counselling service. It is recommended that link counsellors visit A&E, medical and psychiatric services on a regular basis (suggest daily) thus helping to provide links into longer-term treatment services for patients who have been detoxified.
 - d. They will also provide linkages to SMDT.
- 8. A service for homeless people who require detoxification should be established.
 - a. This should be a 24 hour-nurse run service with medical cover on-call.
 - b. In particular, there is a need to develop protocols for referral for acute medical care when required.
- 9. Issues for drugs other than alcohol.
 - a. For opiate users, level-2 trained GPs should be facilitated so that those requiring detoxification from opiates can be commenced on methadone. Adequate professional support should be made available to GPs in the event of complications in patients receiving methadone.
 - b. Support and training should be provided for GPs who have an interest in detoxification for sedatives and hypnotics. The DoHC report (Benzodiazepines – Good Practice Guidelines for Clinicians, 2002) will be important in this regard. The report also recommends that the drug misuse treatment service in each health board draw up guidelines for the management of benzodiazepines within the area.
- 10. General issues;
 - a. Integrated care pathways (protocols) should be developed for each setting of the service e.g. protocols for management of

detoxification in GP, protocols for referrals to various treatment centres and between different detoxification settings.

- b. An agreed minimum dataset should be developed on drug and alcohol detoxification. Consideration could be given to expanding existing datasets such as HIPE, NTDRS and NPIRS etc.
- c. Appropriate training in relation to detoxification and other aspects of drug and alcohol treatment should be provided to all service providers. For GPs, this could be linked with current training, which is provided by the ICGP in relation to Alcohol Aware Practices.
- d. A needs assessment for drug and alcohol services for young people under the age of 18 year should be carried out in Cork and Kerry.

11. Nationally;

- a. A national strategy for the treatment of drug and alcohol misuse, including detoxification, should be developed.

See Chapter 10 for detail on quantification of these recommendations.

CHAPTER TEN RECOMMENDATIONS - QUANTIFIED

In this section the recommendations are quantified in terms of minimum numbers of link counsellors, designated beds for detoxification and number of GPs required to implement the actions outlined in the previous section.

There is no nationally agreed schedule or framework for required staffing levels for levels of service provision in local areas in the UK or Ireland. In some instances, where individuals or groups have made recommendations, these will be referred to.

10.1 LINK COUNSELLORS AND BEDS FOR DETOXIFICATION IN COMMUNITY BY GPs AND DESIGNATED BEDS IN PSYCHIATRY

The minimum proposed numbers in relation to the recommendations are:

- a. One link counsellor per 50,000 population.
- b. One detoxification bed in the community for use by GPs per 50,000 population (suggested locations either current residential treatment services or contracted beds in private hospitals).
- c. One designated detoxification bed per 50,000 population in psychiatric ward for in-patient detoxification of more complex cases.

In 2003, research by Matrix[95] in the UK has estimated that by 2008 one in-patient bed will be needed per 48,000 of the population. This estimate is primarily for in-patient detoxification for drugs other than alcohol but recognises that alcohol is often part of polydrug abuse.

The following table gives a breakdown of these figures by Community Care Service. Two beds were recommended in West Cork for a population of 50,000 because of the large geographical area involved.

Table 10.1 Recommended numbers in relation to service developments for detoxification

Community Care Service	Population	Recommended minimum number of Link counsellors	Recommended minimum numbers of beds available in private hospital or residential treatment centre for detoxification by GPs	Recommended minimum number of designated in-patient detoxification beds in psychiatric / medical hospitals
North Lee	156,036	3	3	3
South Lee	167,479	3	3	3
North Cork	73,511	2	2	2
West Cork	50,803	1	2	1
Kerry	132,527	3	3	3
Total	580,356	12	12	12

10.2 SPECIALIST IN-PATIENT DETOXIFICATION BEDS

It has been recommended that Specialist in-patient beds be designated in psychiatric/ medical wards per 50, 000 of population. This allows for beds in each Community Service Area allowing for a population based geographical spread.

10.3 SPECIALIST SERVICES FOR DETOXIFICATION

Substance misuse detoxification teams including a multidisciplinary team and designated psychiatrist and medical officers should be developed. A minimum of four teams, which could be allocated on a geographical basis e. g. a team each for Cork city, West Cork, North Cork and Kerry is recommended.

10.4 ESTIMATES OF COMMUNITY DETOXIFICATION BEDS BY GPs

The following table gives an estimate of the number of patients that could be detoxified in the community detoxification beds in a year assuming a one week detoxification and 100% occupancy.

Table 10.2 Projections of patient detoxification numbers in GP beds

Community Care Service	Population	Recommended minimum numbers of beds available in private hospital or residential treatment centre for detoxification by GPs	Potential number of patients receiving detoxification in one year (assuming one week detoxification and 100% occupancy)
North Lee	156,036	3	156
South Lee	167,479	3	156
North Cork	73,511	2	104
West Cork	50,803	2	104
Kerry	132,527	3	156
Total	580,356	12	780

10.5 TRAINING FOR GENERAL PRACTITIONERS

10.5.1 Training for alcohol detoxification

It is recommended that at least one GP per 10,000 of the population be identified initially, supported and trained particularly in relation to alcohol detoxification.

Training could be organised following consultation with the Irish College of General Practitioners (ICGP). The Alcohol Aware Practice Pilot Study[81] of the ICGP would be a valuable resource in this regard. This Pilot Study has used training of GPs and key practice staff in relation to screening and detection, treatment and referral of alcohol problems.

Interested GPs should also be identified to develop expertise in the area benzodiazepines detoxification, as this has been identified by GPs the commonest drug requiring detoxification after alcohol.

Table 10.3 gives a breakdown of minimum number of trained GPs per Community Care Service. It also gives some estimated projections of number that could be detoxified by GPs (10 or 20 patients per year).

Table 10.3 Minimum number of GPs given extra support

Community Care Service	Population	Supported GPs for alcohol detoxification (1 GP per 10,000 of population)	Estimated projections of numbers of clients detoxified (e.g. 10 per GP)	Estimated projections of numbers of client's detoxified (e.g. 20 per GP)
North Lee	156,036	16	160	320
South Lee	167,479	17	170	340
North Cork	73,511	7	70	140
West Cork	50,803	5	50	100
Kerry	132,527	13	130	260
Total	580,356	58	580	1160

If all current GPs (423) in the region carried out 6 alcohol detoxifications in the community in a year, (which was the mean estimated number reported by GPs in this survey), there would be a total 2,538 out in the SHB every year.

If this rose to 10 per GP, this would result in 4,230 detoxifications in a year.

10.5.2 Level – 2 methadone training for GPs

Level-2 training should be provided for three GPs at a minimum in Cork and Kerry. Contracts should be entered into with these GPs so that initiation or detoxification using methadone can occur within the region.

Any GP who has already completed the level-2 training should be facilitated to up skill as required.

10.6 DEVELOPMENT OF DETOXIFICATION SERVICES FOR HOMELESS PEOPLE

A 24-hour nurse run service for detoxification should be developed for homeless people preferably attached to a voluntary centre. Medical cover should be available on call.

APPENDICES

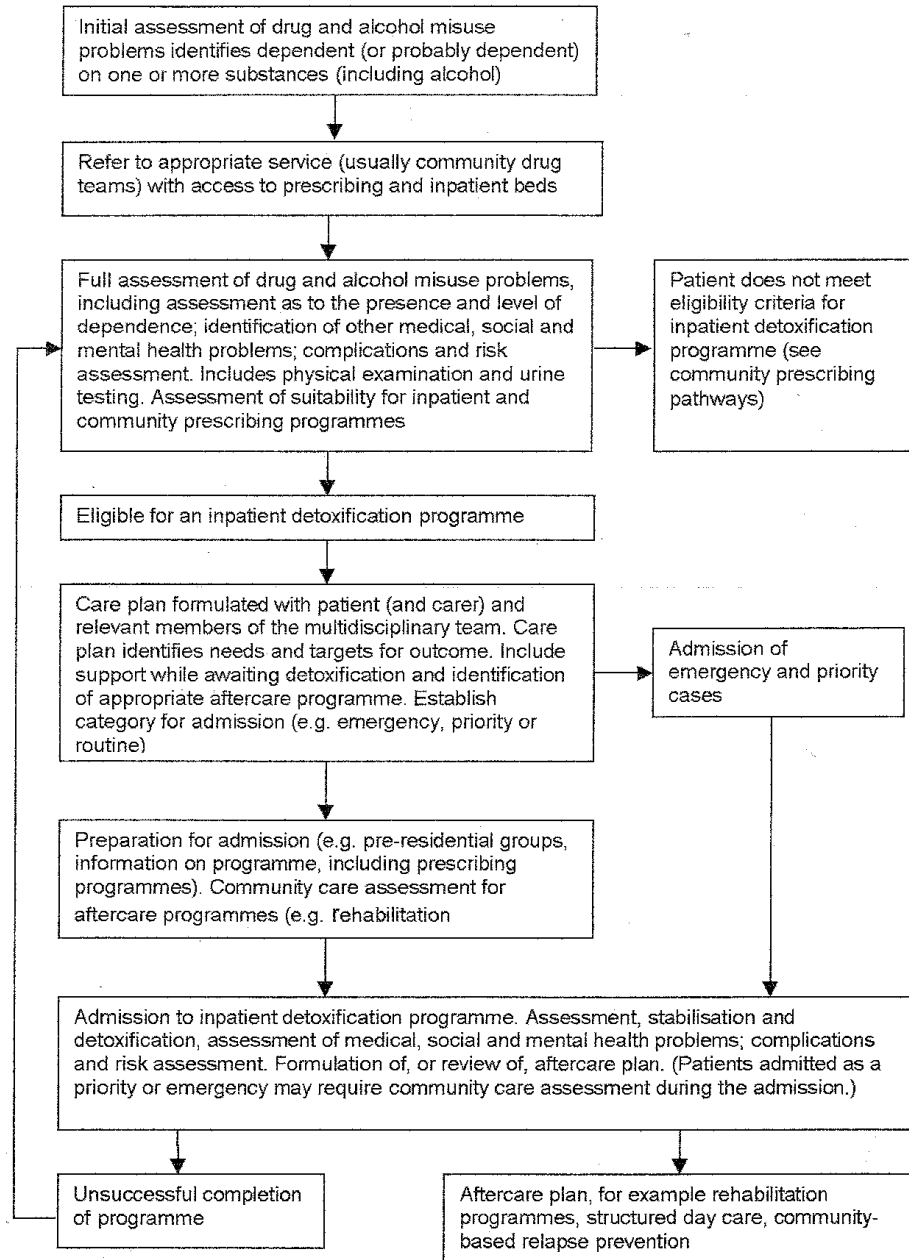
COOKS INTEGRATED RESPONSE FOR ALCOHOL TREATMENT

Item		Functions	Staffing
1	CAT or SMIT Liaison team	Functions multiple, flexible, exploratory and entrepreneurial but likely to include: <ul style="list-style-type: none"> (i) First wave of generalist services collaborations including GPs, general hospitals, district psychiatric and social services; (ii) Liaison with voluntary sector alcohol agencies including AA and AI-Anon; (iii) Immediate specialized service delivery and shared care through outpatient and liaison clinics; (iv) Direct / indirect assistance with detoxification; (v) Professional training; (vi) Overseeing and stimulating prevention; (vii) Special responsibility to liaise with District Drug Dependence Services. 	Half time consultant, half time SR, three-person team with variable skills mix drawn from CPN, SRN, SW, OT, psychologist, with in and out attachments from voluntary agencies, secretarial support.
2	Access to three hospital beds in psychiatric setting (or six bed facility shared by two districts)	Dealing with psychiatric co-morbidity, detoxification of severely dependant patients who cannot be managed in OPD; life saving interventions and suicide prevention; family protection from violence.	Medical cover from liaison team. Full nursing cover, OT, psychology support, investigate facilities.
3	Services for the homeless drinker	Outreach shop front, day centre and hostel facilities.	Likely to be provided by non-statutory agency.
4	Counselling and information centre	Ready access to confidential advice and information in community setting; development of initiatives for special population groups; training of volunteers.	Two or three trained counsellors, volunteers, secretarial support.
5	Ensure that prevention receives adequate attention	Education through schools and workplace; local community action; the GP component.	Liaison team to stimulate and support these activities.
6	Additional resources for liaison team	Functions include: <ul style="list-style-type: none"> (i) Holding in place established collaborations; (ii) Expansion of multidisciplinary training; (iii) Second wave of collaboration, e.g. Courts, workplace programmes; (iv) Development of family support system. 	Add one or more extra staff to mixed skills team, possibly on basis of attachment or training attachment from other statutory or voluntary services.

Reproduced from:
 Health Care Needs Assessment:
 The Epidemiologically based needs assessment reviews.
 Edited by Andrew Stevens and James Raferty
 Chapter on Alcohol Misuse by Christopher Cook 2004. Radcliffe Medical Press.

APPENDIX C

Care pathway for inpatient detoxification (Source NTA Draft Tier 4 briefing 10.12.2003)



Estimated resource levels for specialist treatment services for drug misuse per 0.5 million of the population

Resource	Substance misuse team	Hospital inpatient unit	Residential rehabilitation programme
Consultant psychiatrist	1 wte	0.5 wte	Sessional
Specialist Registrar/other medical	0.5 wte	0.5 wte	2-5 sessions
Staff grade/GP	0.5 wte	0.5 wte	2 sessions
Co-ordinator/Manager	1 wte	1 wte	1 wte
Community Psychiatric Nurse	4-6 wte	6-12 wte	0-0.5 wte
State registered nurse/other nurse	1-5 wte	2-4 wte	1-3 wte
Clinical psychologist/counsellor	0-1 wte	0-0.25 wte	0-3 wte
Social worker	1-2 wte	0.25-0.5 wte	2-4 wte
Drug worker/care worker	1-3 wte	Usually 0	2-4 wte
Administrator/secretary	1-2 wte	1-2 wte	1-2 wte
Coverage	Around 150-200 places/500,000 pop. For maintenance and reduction	8 -20 beds/500,000 pop. +	12-40 beds/500,000 pop. +

Wte=whole time equivalent

*Reflecting the Royal College of Psychiatrists' guidelines on the number of consultants needed at a local level in 1992

Reproduced from:

'Health Care Needs Assessment: The epidemiologically based needs assessment reviews'

Edited by Andrew Stevens and James Raftery

Chapter on Drug Misuse by John Marsden, John Strang with Don Lavoie, Dima Abduirahim, Matthew Hickman, Simon Scott.

2004, Radcliffe Medical Press

Information Sheet for Service Providers Needs Assessment for Detoxification Services for Alcohol and Drug Misuse in the Southern Health Board Area

Aim: to estimate the need for alcohol and drug detoxification services within the Southern Health Board.

Lead Researcher: Dr. Mai Mannix, Specialist Registrar in Public Health Medicine, Department of Public Health, Sarsfield House, Sarsfield Road, Wilton, Cork.
Tel (021)4346060.

The process will involve:

- A. Detailed review of data regarding drug and alcohol detoxification including
 - Review of most recent literature and best practice nationally and internationally
 - Review of all relevant databases
 - Review of current available information on prevalence of alcohol and drug misuse
 - Review of demography and population projections to help estimate future needs for services
- B. Interviews with Service Providers
 - Medical Consultants
 - Psychiatric Clinical Directors, Consultant Psychiatrists
 - A&E Consultants
 - ICGP CME tutors
 - GP trainers
 - GP for Homeless Initiative
 - Co-ordinator for Substance and Alcohol Abuse
 - Managers and service providers from specialist alcohol and drug treatment services
- C. Interviews with Service Users
 - These will be recruited through the statutory drug and alcohol detoxification services.
- D. Questionnaires
 - Non-medical service providers
 - General Practitioners
 - Consultant Psychiatrists
 - Medical Consultants
- E. Analysis of results of questionnaires and interviews

Ethical Approval: has been obtained from the National Research Ethics Committee in the Royal College of Physicians in Ireland.

End Result: Report for Health Board on future needs, type and location of alcohol and drug detoxification services.

**Health Needs Assessment for Drug and Alcohol Detoxification Services
in the Southern Health Board Area.**

Consent Form Service Providers

I have read the information sheet and consent form and I have been given a copy of both to keep. I am aware of the following:

- That taking part in the study is entirely voluntary.
- That the content of the interview that I give will be treated confidentially.
- That my name will not be used in connection with anything I say.
- That the results will be combined so that no individual person can be identified.
- That I am not obliged to answer any question that I am not happy to answer.
- That I may terminate the interview at any time.

I have been given the opportunity to ask questions about the research project. I understand that information will be kept on tape, computer and paper. The tapes will be deleted after a four-month period.

I hereby consent to participate in the research project. YES NO

I hereby consent to the interview being recorded YES NO

I am aware that if I become uncomfortable at any time about being recorded, I will indicate this to the interviewer.

Signed: _____ Date: _____

Witness: _____ Date: _____

Interview Guide Psychiatrists

Health Needs Assessment for Drug and Alcohol Detoxification Services in the Southern Health Board Area.

Section One: Within Psychiatric Setting

- 1. What do you understand by the term ‘detoxification’?**
 - Alcohol,
 - Other drugs.

- 2. What is your experience of detoxification as a psychiatrist in your own practice setting?**
 - Is it a common occurrence in your practice?
 - How many patients approximately have you detoxified for alcohol or drugs within the last three months, six months or year?
 - Comparatively, what proportions are detoxified for alcohol problems alone, illegal drugs alone and or a combination of alcohol and illegal drugs?
 - Have you supervised any alcohol or drug detoxification as referrals from other services?

- 3. How do you detoxify patients for alcohol and other drugs?**
 - How do you select patients for detoxification?
 - In what setting do you detoxify patients for alcohol/ other drugs (psychiatric ward, A&E ward, other)?
 - What medications do you use for alcohol/drug detoxification?
 - Are some patients detoxed without the use of medication?
 - Over what time scale do you normally detoxify patients?
 - Do you have access to a specialist treatment service setting where detoxification can be overseen?
 - On average, is there much professional time for you involved in detoxifying patients for alcohol/other drugs?

- 4. How do you currently access follow-up treatment services for patients who have been detoxified for alcohol/other drugs?**
 - Do you look for commitment to follow-up treatment by the patient before entering alcohol detoxification?
 - In your experience what proportion of patients enter a treatment programme following detoxification for alcohol/other drugs?
 - What proportion stay in treatment?
 - What proportion relapse?
 - What proportion relapse and repeat detoxification?
 - Where do you access follow-up treatment services for patients who have been detoxified for alcohol/other drugs?
 - Do you use community drug and alcohol treatment services, psychiatric services, private treatment centres, other?

5. **How could the access to follow up/treatment services be improved?**

6. **What is working well in the current detoxification service in the psychiatric setting?**
 - Alcohol
 - Other drugs

7. **What is not working well in the current detoxification service in the Psychiatric setting?**
 - Alcohol
 - Other drugs

8. **If you had the opportunity to improve the alcohol/drug detoxification service within psychiatry what would you do?**

Section Two: Detoxification within settings other than psychiatry

9. **Do you refer to other centres for alcohol/drug detoxification services?**
 - If so to what services (Acute medical services, psychiatric services, district hospital, other)
 - Do you have access to a specialist treatment service setting with support staff where detoxification can be overseen?

10. **What is your experience of these services?**
 - Is there easy access?
 - Is there a good follow-up/treatment service?
 - If not, how could this be improved?

11. **How could alcohol/drug detoxification services be developed and improved in the future?**
 - In what setting would you like to see it (e.g. acute medical, specialist detoxification unit)?
 - Do you see a role for community hospitals?

12. **In your experience, what types of patients are suitable for dealing with alcohol/other drug detoxification in the general practice setting?**
 - Is there a potential to deal with more in general practice?
 - If yes, what would facilitate this (e.g.. more training for GPs, fast access to alcohol counselling services)?

13. **Is there anything that you would like to add on the topic of alcohol detoxification or detoxification for other drugs?**

Interview Guide Consultants Medical & Accident and Emergency

Health Needs Assessment for Drug and Alcohol Detoxification Services in the Southern Health Board Area.

Section One: Within own practice Setting

- 1. What do you understand by the term ‘detoxification’?**
 - Alcohol,
 - Other drugs.

- 2. What is your experience of detoxification as a consultant in your own practice setting?**
 - Is it a common occurrence in your practice?
 - How many patients approximately have detoxified for alcohol or drugs within the last three months, six months or year?
 - Comparatively, what proportions are detoxified for alcohol problems alone, illegal drugs alone and or a combination of alcohol and illegal drugs?
 - Have you supervised any alcohol or drug detoxification as referrals from other services?

- 3. How do you detoxify patients for alcohol and other drugs?**
 - How do you select patients for detoxification?
 - In what setting do you detoxify patients for alcohol/ other drugs (Psychiatric ward, A&E ward, other)?
 - What medications do you use for alcohol/drug detoxification?
 - Are some patients detoxified without the use of medication?
 - Over what time scale do you normally detoxify patients?
 - Do you have access to a specialist treatment service setting where detoxification can be overseen?
 - On average, is there much professional time for you involved in detoxifying patients for alcohol/other drugs?

- 4. How do you currently access follow-up treatment services for patients who have been detoxified for alcohol/other drugs?**
 - Do you look for commitment to follow-up treatment by the patient before entering alcohol detoxification?
 - In your experience what proportion of patients enter a treatment programme following detoxification for alcohol/other drugs?
 - What proportion stay in treatment?
 - What proportion relapse?
 - What proportion relapse after detoxification?
 - Where do you access follow-up treatment services for patients who have been detoxified for alcohol/other drugs?
 - Do you use community drug and alcohol treatment services, psychiatric services, private treatment centres, other?

- 5. How could the access to follow up/treatment services be improved?**
- 6. What is working well in the current detoxification service within your practice setting?**
- Alcohol
 - Other drugs
- 7. What is not working well in the current detoxification service within your practice setting?**
- Alcohol
- Other drugs
- 8. If you had the opportunity to improve the alcohol/drug detoxification service within your practice setting what would you do?**

Section Two: Detoxification within settings other than medical/ A&E setting

- 9. Do you refer to other centres for alcohol/drug detoxification services?**
- If so to what services (Acute medical services, psychiatric services, district hospital, other)
 - Do you have access to a specialist treatment service setting with support staff where detoxification can be overseen?
- 10. What is your experience of these services?**
- Is there easy access?
 - Is there a good follow-up/treatment service?
 - If not, how could this be improved?
- 11. How could alcohol/drug detoxification services be developed and improved in the future?**
- In what setting would you like to see it (e.g. acute medical, specialist detoxification unit)?
 - Do you see a role for community hospitals?
- 12. In your experience, what types of patients are suitable for dealing with alcohol/other drug detoxification in the general practice setting?**
- Is there a potential to deal with more in general practice?
 - If yes, what would facilitate this (e.g.. more training for GPs, fast access to alcohol counselling services)?
- 13. Is there anything that you would like to add on the topic of alcohol detoxification or detoxification for other drugs?**

Interview Guide General Practitioners

Health Needs Assessment for Drug and Alcohol Detoxification Services in the Southern Health Board Area.

Section One: Within General Practice Setting

- 1. What do you understand by the term ‘detoxification’?**
 - Alcohol.
 - Other drugs.

- 2. What is your experience of detoxification as a general practitioner in your own practice setting?**
 - Is it a common occurrence in your practice?
 - How many patients approximately have you detoxified for alcohol or drugs within the last three months, six months or year?
 - Have you supervised any alcohol or drug detoxification as referrals from other services?

- 3. How do you detoxify patients for alcohol and other drugs?**
 - How do you select patients for detoxification?
 - In what setting do you detoxify patients for alcohol/ other drugs?
 - Do you detoxify patients in their own homes, community hospital or elsewhere?
 - What medications do you use for alcohol/drug detoxification?
 - Are some patients detoxed without the use of medication?
 - Over what time scale do you normally detoxify patients?
 - In your experience does your practice nurse or the area public health nurse have any role currently in alcohol/other drug detoxification?
 - On average, is there much professional time for you involved in detoxifying patients for alcohol/other drugs in the community?

- 3. In your experience, what types of patients are suitable for dealing with alcohol/other drug detoxification in the general practice setting?**
 - Is there a potential to deal with more in general practice?
 - If yes, what would facilitate this (e.g.. more training for GPs, fast access to alcohol counselling services)?

- 4. How do you currently access follow-up treatment services for patients who have been detoxified for alcohol/other drugs?**
 - Do you look for commitment to follow-up treatment by the patient before entering alcohol detoxification?
 - In your experience what proportion of patients enter a treatment programme following detoxification for alcohol/other drugs?
 - What proportion stay in treatment?

- What proportion relapse?
- What proportion relapse and repeat detoxification?
- Where do you access follow-up treatment services for patients who have been detoxified for alcohol/other drugs?
- Do you use community drug and alcohol treatment services, psychiatric services, private treatment centres, other?

5. How could the access to follow up/treatment services be improved?

6. What is working well in the current detoxification service in a general practice setting?

- Alcohol
- Other drugs

8. What is not working well in the current detoxification service in a general practice setting?

- Alcohol
- Other drugs

9. If you had the opportunity to improve the alcohol/drug detoxification service within general practice, what would you do?

Section Two: Detoxification within settings other than general practice.

10. Do you refer to other centres for alcohol/drug detoxification services?

- If so to what services (Acute medical services, psychiatric services, district hospital, other)
- Do you have access to a specialist treatment service setting with support staff where detoxification can be overseen?

11. What is your experience of these services?

- Is there easy access?
- Is there a good follow-up/treatment service?
- If not how could this be improved?

12. What detoxification services would you like to see outside the general practice setting in the future?

- In what setting would you like to see it (e.g. acute medical, specialist detoxification unit)?
- Do you see a role for community hospitals?

13. Is there anything that you would like to add on the topic of alcohol detoxification or detoxification for other drugs?

Interview Guide Specialist Addiction Counselling Service Providers

Health Needs Assessment for Drug and Alcohol Detoxification Services in the Southern Health Board Area.

Section One: Within Own Practice Setting

- 1. I would just like to check a few details before we begin.**
 - In what service do you work?
 - (Community drug and alcohol treatment service, voluntary or statutory, residential or non-residential?)
 - What geographical area does your service cover?
 - What is your job title?
 - Are you in a full-time management post or do you work in a therapeutic setting or are you in a combination of work?
 - Do you have an area of particular expertise (e.g. drugs, alcohol, homeless)?

- 2. What do you understand by the term ‘detoxification’?**
 - Alcohol,
 - Other drugs.

- 3. What is your experience of detoxification in your own practice setting?**
 - Is it a common occurrence in your work?
 - How many patients approximately that you come into contact with have been detoxified for alcohol or drugs within the last three months, six months or year?
 - Comparatively, what proportions are detoxified for alcohol problems alone, illegal drugs alone and or a combination of alcohol and illegal drugs?

- 4. Are clients detoxified for alcohol within the treatment service that you work in?**
 - Have they already been detoxified if necessary by another service before they reach your treatment service?
 - If so what is the proportion of clients approximately who are detoxified by each of the services? (Acute medical, psychiatric, district hospital, other)?
 - Have you had any direct experience supervising clients who are undergoing detoxification?

- 5. Do you refer to other centres for alcohol/drug detoxification services?**
 - If so to what services (Acute medical services, psychiatric services, district hospital, other)
 - Do you have access to a specialist treatment service setting with support staff where detoxification can be overseen?

- 6. What is your experience of these services?**
 - Is there easy access?

- Is there a good follow-up/treatment service?
 - If not how could this be improved?
- 7. In your experience, how is access to follow-up treatment services obtained for clients who have been detoxified for alcohol/other drugs?**
- Do you look for commitment to follow-up treatment by the patient before entering alcohol detoxification?
 - In your experience what proportion of patients enter a treatment programme following detoxification for alcohol/other drugs?
 - What proportion stay in treatment?
 - What proportion relapse?
 - What proportion relapse and repeat detoxification?
 - Where do you access follow-up treatment services for patients who have been detoxified for alcohol/other drugs?
 - Do you use community drug and alcohol treatment services, psychiatric services, private treatment centres, other?
- 8. How could the access to follow up/treatment services be improved?**
- 9. What is working well in the current detoxification service?**
- Alcohol, other drugs
 - Settings, general practice, acute care, psychiatric services, addiction treatment services.
- 10. What is not working well in the current detoxification service?**
- Alcohol, other drugs
 - Settings, general practice, acute care, psychiatric services, addiction treatment services.
- 11. If you had the opportunity to improve the alcohol/drug detoxification service, what would you do?**
- Alcohol, other drugs
 - Settings, general practice, acute care, psychiatric services, addiction treatment services.

Section Two: Detoxification within settings other than general practice

- 12. In your experience, what types of patients are suitable for dealing with alcohol/other drug detoxification in the general practice setting?**
- Is there a potential to deal with more in general practice?
 - If yes, what would facilitate this (e.g.. more training for GPs, fast access to alcohol counselling services)?
- 13. What alcohol detoxification services would you like to see outside the general practice setting in the future?**
- In what setting would you like to see it (e.g. acute medical, specialist detoxification unit)?
 - Do you see a role for community hospitals?
 - Is there anything that you would like to add on the topic of alcohol detoxification or detoxification for other drugs?

Tabor Lodge, Drug and Alcohol Treatment Service
Identification of patients for inclusion in the Needs Assessment in Alcohol and
Drugs Detoxification Study

Patient ID number _____
 Community Care Area _____
 Date of Birth _____
 Date admitted to Tabor Lodge _____

Q1 What is client's sex?

Male	Female
------	--------

Q2 Was client detoxified for any of the following within 3 months prior to today?

Alcohol alone	Yes	No
Illicit use of drugs without alcohol	Yes	No
A combination of alcohol and use of other drugs	Yes	No

Q3 Did the client have previous detoxifications within the last year for alcohol alone, illicit use of drugs or a combination?
 If yes, how many detoxifications within the last year?

Yes	No
-----	----

Q4 Please specify which substances were used within the month prior to detoxification?

Alcohol	Yes	No
Cannabis	Yes	No
Ecstasy	Yes	No
Hallucinogens	Yes	No
Inhalants	Yes	No
Cocaine	Yes	No
Heroin	Yes	No
Methadone	Yes	No
Other opiates	Yes	No
Tranquillisers Prescribed	Yes	No
Tranquillisers Non-Presc.	Yes	No
Sedatives Presc	Yes	No
Sedatives Non-Presc	Yes	No
Analgesics Presc	Yes	No
Analgesics Non-Presc	Yes	No

Q5 In which setting did detoxification occur?
 Please tick appropriate setting

Acute Medical Ward	
Psychiatric Ward	
General Practice	
Tabor Lodge	
Other setting	

If other, please specify _____

Q6 Client inclusion criteria

Client aged 18 years or over	Yes	No
Client orientated in time, place or person	Yes	No
Client detoxified within the previous month	Yes	No

Q7 Client exclusion criteria

Client under 18 years of age?	Yes	No
Client psychotic	Yes	No
Client with learning disability	Yes	No
Client not detoxified within the previous 3 months	Yes	No
Client not oriented in time, place or person	Yes	No

If other, please specify _____

Q8 Is client willing to speak with researcher?

Yes	No
-----	----

Signed _____ Date _____
Administrator, Tabor Lodge

Your Views Count!

Health Needs Assessment for Drug and Alcohol Detoxification Services in the Southern Health Board Area.

Information Sheet for Service Users

About the study

- The study is being carried out to see what services are needed for detoxification for drug and alcohol problems in the Southern Health Board area.
- We need to get the views of people who have used the present services.
- We will also be looking for the views of those people who provide the services.
- Based on the findings and the most up to date literature, recommendations will be made regarding the need and type of alcohol and drug detoxification services in future.

About taking part in the study

- Your decision to take part in the study is entirely voluntary.
- Whether you decide to take part in the study or not will not in any way affect the treatment/clinical care that you receive.
- It has been explained that an addiction counsellor will be available to me if necessary during or after the interview
- All information will be treated confidentially.
- The information that you give will not in any way identify you.
- The information will be held on paper and computer and will only be seen by Dr. Mai Mannix and Ms. Heather Hegarty A/Senior Research Officer.
- The information obtained will only be tape recorded with your consent.
- You are not obliged to answer any question that you are not happy to answer
- If the unlikely event that the interview becomes upsetting for you a counsellor from the drug and alcohol treatment service will be available to meet with you.
- It offers a unique chance to have your views heard.

Health Needs Assessment for Drug and Alcohol Detoxification Services in the Southern Health Board Area.

Consent Form Service Users

I have read the information sheet and consent form and I have been given a copy of both to keep. I am aware of the following:

- That taking part in the study is entirely voluntary.
- That the content of the interview that I give will be treated confidentially.
- That my name will not be used in connection with anything I say.
- That the results will be put together so that no individual person can be identified.
- That I am not obliged to answer any question that I am not happy to answer.
- That I may terminate the interview at any time.

I have been given the opportunity to ask questions about the research project. I understand that information will be kept on tape, computer and paper. The tapes will be deleted after a four-month period.

I hereby consent to participate in the research project. YES NO

I hereby consent to the interview being recorded YES NO

I am aware that if I become uncomfortable at any time about being recorded, I will indicate this to the interviewer.

Signed: _____ Date: _____

Witness: _____ Date: _____

Interview Guide Service Users

Health Needs Assessment for Drug and Alcohol Detoxification Services in the Southern Health Board Area

Section One

- 1. Alcohol and drug profile.**
 - I would like to check with you regarding your use of alcohol and illicit drugs over the last year.
- 2. What do you understand by the term detoxification for alcohol or drugs?**
- 3. When did you last receive detoxification?**
 - Was this for alcohol, other drugs or a combination of drugs and alcohol?
- 4. What professional helped you with your last detoxification?**
 - GP, Psychiatrist, Consultant, Medical Officer in Arbour House, other?
- 5. Did you enter into a commitment of any kind with the doctor/professional to enter into a treatment programme before you received detoxification?**
 - What kind of commitment, a promise, a written statement
- 6. In what setting did you receive detoxification?**
 - At home, medical ward, A&E ward, psychiatric ward, other.
- 7. What worked well for you in your last detoxification?**
- 8. What did not work well for you in your last detoxification?**
- 9. If you had the opportunity to develop a better way of doing things, what would you do?**
- 10. Did you find that it was easy for you to get into a follow-up/treatment service having been detoxified?**
 - If you found it difficult, why was this the case?
 - What would make it better?
- 11. Have you ever been detoxified previously?**
 - If so, when were you detoxified?
 - Detoxified for alcohol only
 - Detoxified for other drug use
 - Detoxified for a combination of alcohol and drugs?
 - Can you remember when these occurred?
- 12. What worked well for you in your previous detoxifications?**
- 13. What did not work well for you in your previous detoxifications?**
- 14. From those experiences of previous detoxifications, if you had the opportunity to develop a better way of doing things, what would you do?**
- 15. As a result of previous detoxifications, did you enter into a treatment programme?**
 - If not, why not?
- 16. Is there anything you would like to add on the topic of alcohol and drug detoxification?**

**Needs Assessment Drug and Alcohol Detoxification Services
Southern Health Board
Confidential Questionnaire for Medical Service Providers**

Detoxification provides supervised withdrawal from a drug of dependence so that the severity of withdrawal symptoms and serious medical complications are reduced to a minimum.

Please answer all questions by crossing the appropriate box, or clearly writing in the space provided

This questionnaire takes approximately 10 minutes to complete

Section A: Background Details

Q1 Are you:

A Psychiatrist

A Medical Consultant

An A&E Consultant

A General Practitioner

Q2 What age group are you:

i) <30 ii) 30-39

iii) 40 - 49 iv) 50 - 59

v) >60

Section B: Detoxification for Alcohol

Q3 Do you undertake detoxification of patients for alcohol?

Yes No

If no, please go to Q.5.

If yes, how many patients approximately have you detoxified within the last year?

Q4 In what setting do you detoxify patients for alcohol?

i) Psychiatric Ward as an In-patient Yes No ii) Acute Medical Ward Yes No

iii) A&E Ward Yes No iv) Psychiatric Out-patient Yes No

v) Community Hospital Yes No vi) As a patient in the community Yes No

vii) Other Yes No
If other, please specify:

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Q5 Do you access other services for alcohol detoxification outside of your own services? Yes No

If no, please go to Q.7.

If yes, where is this service located?

i) Psychiatric Inpatient Yes No

ii) Acute Medical Ward Yes No

iii) A&E Ward Yes No

iv) Psychiatric Out-patient Yes No

v) Community Hospital Yes No

vi) Cuan Mhuire, Bruree, Co. Limerick Yes No

vii) Other Yes No

If other, please specify:

Q6 Do you have difficulty accessing other services for alcohol detoxification services outside of your own service when you require them? Yes No

If yes, please answer part A and B:

A) Which services are difficult to access:

i) Psychiatric Admission Ward as an Inpatient Yes No

ii) Acute Medical Ward Yes No

iii) A&E Ward Yes No

iv) Psychiatric Out-patient Yes No

v) Community Hospital Yes No

vi) Other Yes No

If other please specify:

B) How do you think access to these other services for detoxification could be improved?

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Q7 Do you have access to follow up treatment following detoxification for your patients with alcohol problems?

Yes No

If yes, where do you access follow up treatment following detoxification for your patients with alcohol problems?

i) Within the psychiatric service Yes No

ii) Community Drug and Alcohol Treatment Services
(e.g. Arbour House and community based addiction counsellors) Yes No

iii) Tabor Lodge Yes No

iv) Talbot Grove Yes No

v) Anchor Treatment Centre, Mallow Yes No

vi) Cuan Mhuire, Bruree, Co. Limerick Yes No

vii) Alcoholics Anonymous Yes No

viii) Other Yes No

If other, please specify:

Section C: Detoxification for Drugs Other than Alcohol

Q8 Do you supervise detoxification for drugs other than alcohol within your own practice setting?

Yes No

If yes, please specify which drugs:

i) Cannabis Yes No

ii) Solvents Yes No

iii) Ecstasy Yes No

iv) Stimulants other than ecstasy (e.g. amphetamines, cocaine, crack) Yes No

v) Sedatives/hypnotics (e.g. tranquilizers, Temazepam, Temagesic) Yes No

vi) Opiates (e.g. heroin, methadone, DF118s) Yes No

vii) Other Yes No

If other, please specify:



Section D: Satisfaction Levels with Detoxification Services for Drugs and Alcohol

Q9 Please rate your satisfaction with the following:

- | | Very Satisfied | Satisfied | Neither | Dissatisfied | Very Dissatisfied |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| i) Current alcohol detoxification services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ii) Current detoxification services for drugs other than alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| iii) Follow up addiction treatment services following detoxification for drugs and alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| iv) Level of communication/liaison between detoxification and addiction treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

Section E: The Future of Detoxification Services for Alcohol and Drugs

Q10 Is there a potential for more detoxification for alcohol to be carried out by general practitioners?

Yes No

If yes, please rank the following in order of importance from 1 to 8 (1 = most important and 8 = least important)

- i) Clear protocols on detoxification within general practice for general practitioners
- ii) Shared care between GPs and Psychiatry in relation to detoxification
- iii) Prompt access to treatment services post detoxification when required
- iv) Access to advice at a local level from community alcohol counselling service
- v) Access to advice at a local level from specially trained Community Psychiatric Nurses
- vi) Availability of visiting nurses to administer anxiolytic drugs in the home under the supervision of a GP
- vii) Training for GPs
- viii) Other
If other, please specify:



Q11 Is there a potential for some detoxification for alcohol to be carried out in community hospitals?

Yes No

If yes, please rank in order of importance from 1 to 3 (1 = most important and 3 = least important)

i) Clear protocols on detoxification for community hospital staff/general practitioners

ii) Prompt access to acute hospital facility as necessary

iii) Other

If other, please specify:

Q12 In your view, where is the most appropriate place for inpatient alcohol detoxification?

Please rank in order of importance from 1 to 6 (1 = most important and 6 = least important)

i) Psychiatric Ward as Inpatient ii) Acute Medical Ward

iii) A&E Ward iv) Specialist Detoxification Unit

v) Community Hospital vi) Other

If other, please specify:

Q13 Do you see a need for a specialist in-patient detoxification unit in the SHB:

Yes No

If yes, please answer Part A and B below

Part A - Which one of the following would you choose as a priority? (Please tick one option)

i) Detoxification Unit for alcohol alone

or

ii) Detoxification Unit for drugs alone

or

iii) Detoxification Unit for both alcohol and drugs

Part B - Who in your opinion should oversee the unit?

i) Psychiatrist with Specialist Training in Detoxification/ Addiction Yes No

ii) Psychiatrist with an interest in the area of Detoxification/Addiction but no Specialist Training Yes No

iii) Medical Consultant Yes No

iv) A&E Consultant Yes No

v) Other Yes No

If other, please specify:

Q14 Do you see a need to develop alcohol 'drunk tanks' or sobering centres (where people who are drunk are allowed to sleep overnight and are assessed the following day for further detoxification or treatment or discharge)?

Yes No

Comment:

Q15 Does follow up treatment service following detoxification for alcohol and drugs require further development?

Yes No

If yes, please rank in order of importance from 1 to 7 (1 = most important and 7 = least important)

- i) Addiction counsellors who are jointly appointed working between detoxification services and alcohol treatment services
- ii) Protocols for referrals and feedback between your service and current community based drug and alcohol treatment services (e.g. Arbour House and community based counsellors)
- iii) More outreach community based drug and alcohol counsellors (e.g. Arbour House) independent of the Psychiatric services
- iv) Protocols for referrals and feedback between your service and current voluntary drug and alcohol treatment services (e.g. Tabor Lodge and Talbot Grove)
- v) Community based drug and alcohol counsellors within the Psychiatric services
- vi) Alcohol Specialist Nurses employed in A&E Departments
- vii) Other option(s) not outlined above, please specify:

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Q16 From your experience, is there a need to develop services for detoxification for opiates (e.g. heroin) in the Southern Health Board region?

Yes No

If yes, which of the following would you like to see developed: Please tick one option only

i) Detoxification using methadone within general practice setting
or

ii) Detoxification within a specialist detoxification unit
or

iii) Detoxification using methadone in general practice and a specialist detoxification unit
or

iv) Other

If other, please specify:

Q17 From your experience, is there a need to develop services for detoxification for drugs other than opiates (e.g. tranquilizers, cocaine) in the SHB region?

Yes No

If yes, how would you like to see the service being developed?

Q18 Can you identify areas of unmet need in relation to detoxification services for drugs and alcohol that need to be addressed?



Q19 Is there anything else you would like to add on the topic of detoxification for drugs and alcohol?

Please return your completed questionnaire by **June 30th**, in the prepaid envelope to:
Ms. Noelle Millar, Public Health Researcher, Dept. of Public Health, Sarsfield House, Wilton, Cork

Thank you for taking the time to complete this questionnaire

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**Needs Assessment Drug and Alcohol Detoxification Services
Southern Health Board
Confidential Questionnaire for Specialised Addiction Counselling Service Providers**

Detoxification provides supervised withdrawal from a drug of dependence so that the severity of withdrawal symptoms and serious medical complications are reduced to a minimum

Please answer all questions by crossing the appropriate box, or clearly writing in the space provided

The questionnaire takes approximately 10 minutes to complete

Section A: Background Details

Q1 In which drug and alcohol treatment service do you work?

i) Within the statutory (Health Board) services Yes No

ii) Within the voluntary services Yes No

Q2 What age group are you in:

i) <30 ii) 30-39

iii) 40-49 iv) 50-59

v) >60

Section B: Detoxification for Alcohol

Q3 Is detoxification of clients for alcohol undertaken within your own service? Yes No

If yes, is this detoxification service provided by:

i) a general practitioner who specifically works with your service Yes No

ii) the client's usual general practitioner Yes No

iii) other Yes No

If other, please specify:

Q4 Do you access other services for alcohol detoxification for your clients outside of your own services? Yes No

If no, please go to Q.6.

If yes, where is this service located?

i) Psychiatric Inpatient Yes No

ii) Acute Medical Ward Yes No

iii) A&E Ward Yes No

iv) Psychiatric Out-patient Yes No

v) Community Hospital Yes No

vi) Cuan Mhuire, Bruree Yes No

vii) Other Yes No

If other, please specify:

Section C: Detoxification for Drugs Other Than Alcohol

Q7 Is detoxification of clients for drugs other than alcohol undertaken within your own service?

Yes No

Do you sometimes meet clients who need detoxification for drugs other than alcohol?

Yes No

If yes, please specify which drugs:

i) Cannabis Yes No

ii) Solvents Yes No

iii) Ecstasy Yes No

iv) Stimulants other than ecstasy (e.g. amphetamines, cocaine, crack) Yes No

v) Sedatives/hypnotics Yes No

vi) Opiates (e.g. heroin, methadone, DF118s) Yes No

vii) Other Yes No

If other, please specify:

Section D: Satisfaction Levels with Detoxification Services for Drugs and Alcohol

Q8 Please rate your satisfaction with the following:

	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied
i) Current alcohol detoxification services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Current detoxification services for drugs other than alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Follow up addiction treatment services following detoxification for drugs and alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Level of communication/liaison between detoxification and addiction treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Section E: The Future of Detoxification Services for Alcohol and Drugs

Q9 Is there a potential for more alcohol detoxification to be carried out by general practitioners?

Yes No

If yes, please rank the following in order of importance from 1 to 8 (1=most important and 8 = least important)

- i) Clear protocols on detoxification within general practice for general practitioners
- ii) Shared care between GPs and Psychiatry in relation to detoxification
- iii) Prompt access to treatment services post detoxification when required
- iv) Access to advice at a local level from community alcohol counselling service
- v) Access to advice at a local level from specially trained Community Psychiatric Nurses
- vi) Availability of visiting nurses to administer anxiolytic drugs in the home under the supervision of a GP
- vii) Training for GPs
- viii) Other

If other, please specify:

Q10 Is there a potential for some detoxification for alcohol to be carried out in community hospitals?

Yes No

If yes, please rank in order of importance from 1 to 3 (1=most important and 3=least important)

- i) Clear protocols on detoxification for community hospital staff/general practitioners
- ii) Prompt access to acute hospital facility as necessary
- iii) Other

If other, please specify:



Q11 In your view, where is the most appropriate place for Inpatient alcohol detoxification?

Please rank in order of importance from 1 to 6 (1 = most important and 6 = least important)

i) Psychiatric Ward as Inpatient

ii) Acute Medical Ward

iii) A&E Ward

iv) Specialist Detoxification Unit

v) Community Hospital

vi) Other

If other, please specify:

Q12 Do you see a need for a specialist inpatient detoxification unit in the SHB?

Yes No

If yes, please answer Part A and B

A) Which one of the following would you choose as a priority? (Please tick one option)

i) Detoxification Unit for alcohol alone

or

ii) Detoxification Unit for drugs alone

or

iii) Detoxification Unit for both alcohol and drugs

B) Who in your opinion should oversee the unit?

i) Psychiatrist with Specialist Training in Detoxification/Addiction Yes No

ii) Psychiatrist with an interest in the area of Detoxification/Addiction but no Specialist Training Yes No

iii) Medical Consultant Yes No

iv) A&E Consultant Yes No

v) Other

Yes No

If other, please specify:

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Dept. of Public Health, Southern Health Board

Q13 Do you see a need to develop alcohol 'drunk tanks' or sobering centres (where people who are drunk are allowed to sleep overnight and are assessed the following day for further detoxification or treatment or discharge)?

Yes No

Comment:

Q14 Does follow up treatment service following detoxification for alcohol and drugs require further development?

Yes No

If yes, please rank in order of importance from 1 to 7 (1= most important and 7 = least important)

- i) Addiction counsellors who are jointly appointed working between detoxification services and alcohol treatment services
- ii) Protocols for referrals and feedback between detoxification services and current community based drug and alcohol treatment services (e.g. Arbour House and community based counsellors)
- iii) More outreach community based drug and alcohol counsellors (e.g. Arbour House) independent of the Psychiatric services
- iv) Protocols for referrals and feedback between detoxification services and current voluntary drug and alcohol treatment services (e.g. Tabor Lodge and Talbot Grove)
- v) Community based drug and alcohol counsellors within the Psychiatric services
- vi) Alcohol Specialist Nurses employed in A&E Departments
- vii) Other option(s) not outlined above

Please specify:



Q15 From your experience, is there a need to develop services for detoxification for opiates (e.g. heroin) in the Southern Health Board region?

Yes No

If yes, which of the following would you like to see developed. (Please tick one option only)

i) Detoxification using methadone within general practice setting
or

ii) Detoxification within a specialist detoxification unit
or

iii) Detoxification using methadone in general practice and a specialist detoxification unit
or

iv) Other

If other, please specify:

Q16 From your experience, is there a need to develop services for detoxification for drugs other than opiates (e.g. tranquilizers, cocaine) in the SHB region?

Yes No

If yes, how would you like to see the service being developed?

Q17 Can you identify areas of unmet need in relation to detoxification services for drugs and alcohol that need to be addressed?



Q18 Is there anything else you would like to add on the topic of detoxification for drugs and alcohol?

Please return your completed questionnaire in the prepaid envelope by **June 30th** to:
Ms. Noelle Millar, Public Health Research Officer, Dept. of Public Health, Sarsfield House, Wilton, Cork

Thank you for taking the time to complete this questionnaire

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ICD CODES

CODE	DESCRIPTION
303	Alcohol dependence syndrome
	A state, psychic and usually also physical, resulting from taking alcohol, characterised by behavioural and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence; tolerance may or may not be present. A person may be dependent on alcohol and other drugs; if so also make the appropriate 304 coding. If dependence is associated with alcoholic psychosis or with physical complications, <i>both</i> should be coded.
305	Nondependent abuse of drugs
	Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent (as defined in 304.-) and that he has taken on his own initiative to the detriment of his health or social functioning. When drug abuse is secondary to a psychiatric disorder, code the disorder.
980	Toxic effect of alcohol
	980.0 <i>Ethyl alcohol</i>
292	Drug psychosis
	Syndromes that do not fit the description given in 295-298 (nonorganic psychoses) and which are due to consumption of drugs [notably amphetamines, barbiturates and the opiate and LSD groups] and solvents. Some of the syndromes in this group are not as severe as most conditions labelled "psychotic" but they are included here for practical reasons. Use additional E Code to identify the drug and also code drug dependence (304.-) if present.
304	Drug dependence
	A state, psychic and sometimes also physical, resulting from taking a drug, characterized by behavioural and other responses that always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.

Estimating the required capacity of alcohol treatment services

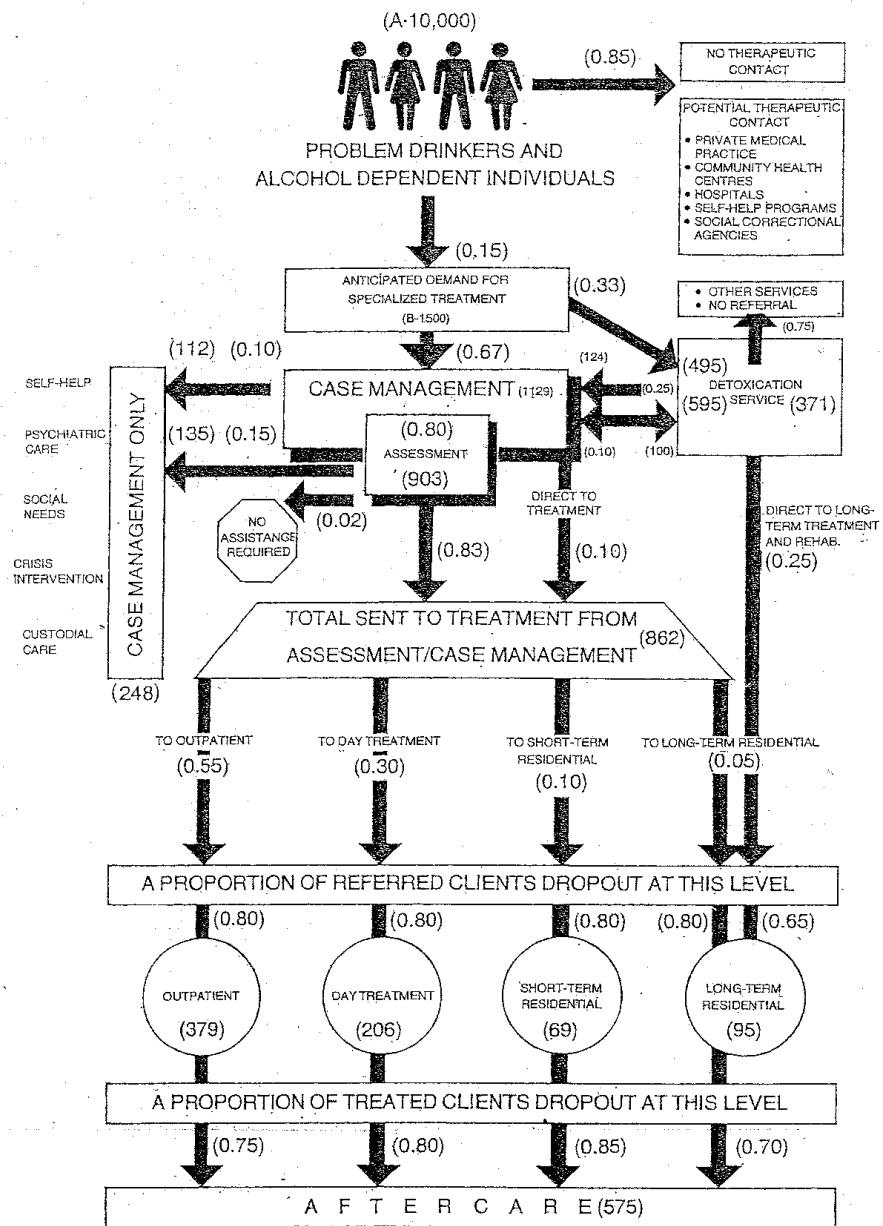


Figure 1. Schematic diagram of client's progression through a comprehensive continuum of care.

NDTRS - National Drug Treatment Reporting System

Drug Misuse Research Division, Health Research Board

First Name Address
 Last Name
 1. Health Board 2. Centre 3. Client No.

A Treatment contact details

4. Date of Treatment Contact
5. Type of Contact with THIS Centre
 1. new client 2. old client 3. not known
6. Ever Previously Treated for Drug Misuse
 1. never treated 2. previously treated 3. not known
7. Currently in Treatment Elsewhere
 1. yes 2. no 3. not known
 If yes, please specify where: _____
8. Source of Referral
 1. self 2. family 3. friends 4. aftercare treatment centre 5. general practitioner 6. hospital medical agency 7. social services 8. court/protection police 9. other 10. not known

B Socio-demographic information

9. Gender
 1. male 2. female
10a. Age
10b. Date of Birth
11a. Living Status (with whom)
 1. alone 2. partner (single) 3. friends 4. partner (couple) 5. partner & children 6. alone with children 7. other 8. not known
11b. Living with Drug Misuser(s)
 1. yes 2. no 3. not known
11c. Living Status (where)
 1. stable accommodation 2. institution (prison, etc) 3. homeless 4. other unstable accommodation 5. age known
12a. City / County
12b. Area of Residence
 OED Code

13. Nationality
 1. Irish 2. Other 3. not known
 If other please specify nationality: _____
14. Employment Status
 1. in paid employment 2. unemployed 3. FASD training course 4. student 5. housewife/husband 6. retired unable to work 7. other 8. not known
15a. Education - Highest Level Reached
 1. primary level 2. secondary level 3. third level 4. never went to school 5. still in education 6. not known
15b. Age Left School years (or specify when not known)
 01. never went to school 02. still at school 03. not known

C Problem drug-use

Drug Name	Route of Administration	Frequency of Use Past Month	Age at 1st use	Duration of Regular Use
16. Main Drug (incl. alcohol)				
17. Drug 2				
18. Drug 3				
19. Drug 4				
	1. inject 2. smoke 3. eat/drink 4. sniff	1. once a week or less 2. 2-6 days per week 3. daily 4. no use past month		
20. Age First Used Any Drug (incl. alcohol)	<input type="text"/> <input type="text"/>			

D Risk behaviour

21a. Injected in Past Month
 1. yes 2. no 3. not known
21b. Shared Past Month
 1. yes 2. no 3. not applicable (not injecting) 4. not known
22a. Ever Injected
 1. yes 2. no 3. not known
22b. If Yes, Age First Injected
22c. Ever Shared
 1. yes 2. no 3. not applicable (never injected) 4. not known

E Action

23. Type of Treatment
 1. detoxification/short term reduction 2. long-term substitution/maintenance 3. medication/peer psychological therapy 4. advice/counseling/support 5. social and/or occupational reintegration 6. other (specify) 9. not known
 If relevant please specify substance drug:
 a. methadone b. buprenorphine c. other opiate d. other substitute drug (specify) 4. not known



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