

**REPORT ON DEVELOPING AN OPERATIONAL PLAN
FOR DRUG AND ALCOHOL SERVICES IN THE
SOUTH EAST REGION**

Barry Cullen

Addiction Research Centre, TCD

January, 2005

1 INTRODUCTION

- 1.1 *Background:* This report arises from a forum of personnel working in the drug and alcohol services in the Health Services Executive (HSE) (South East) formerly the South Eastern Health Board (SEHB), during November 2003. The purpose of this forum was to bring professionals together to discuss the development of services in the region. The forum was facilitated by Barry Cullen, author of this report, who, afterwards was requested by management to engage in further discussions with drug and alcohol personnel, as part of an overall process of bringing forward an operational plan for the development of substance misuse services in HSE (South East).
- 1.2 *Context:* In developing this task it was advised that the operational plan be located within the context of the *National Drug Strategy (2001)* (NDS) and a regional document, *Working Group on Treatment and Rehabilitation Recommendations (2001)* (commonly referred to as working group recommendations - WGR). Both these documents are concerned *inter alia* with developing community, localised models of service provision. While the NDS is a strategy for dealing with drugs only, the WGR embraces both drugs and alcohol.
- 1.3 *Focus groups:* In undertaking this task the main method was to consult with relevant personnel on an area-basis (Carlow/Kilkenny, Sth. Tipperary, Waterford,

Wexford) through focus groups and one-to-one interviews as a follow-up. Focus groups consisted of an exercise and discussion designed to explore the following issues in a general manner:

- how drug and alcohol problems are defined?
- personnel who need to be involved in treating these problems;
- how integrated management and service delivery is best achieved?

- 1.4 *Interviews:* Twenty-three separate interviews, exploring the same, above questions in a more specific manner and also exploring respondents' understanding of and response to NDS and WGR were also held. Two similarly-focused interviews were also held with the Regional Drugs Coordinator.
- 1.5 *Feedback:* A 2nd focus group was held in each area also and this group was part feedback, part gathering of further thoughts and information. The report below arises out of these various discussions and it also draws from some of the relevant literature and policy reports
- 1.6 *Report outline:* The report is presented in six sections – including this introduction, - and an appendix. In *second* section, there is an outline of two conceptual models for viewing drug and alcohol treatment systems. *Third*, there is an outline of the policy context of drugs and alcohol services. The *fourth* section considers progress in the development of services in keeping with policy aims, in terms of both in-patient services and community-based services. *Fifth*, there is an

assessment of policy implementation and change, and *sixth*, there is an outline of six recommendations. The *appendix* is an elaboration of one of these recommendations.

1.7 *Acknowledgement:* The author of this report would like to thank the personnel in drug and alcohol services who participated in focus groups and interviews, and shared their experiences and reflections for the purpose of this report. The work of Martina Kidd in contributing to the compilation of figures used in this report is also acknowledged.

2. CONCEPTUAL MODELS FOR TREATMENT SYSTEMS

2.1 There are basically two conceptual models for exploring drug and alcohol problem treatment systems

- the disease model
- the public health model

2.2 *The disease model*

2.2.1 Although the treatment of addictions in various shapes has been taking place for about 200 years, the birth of modern treatment commenced during the decades following the repeal of US prohibition on alcohol. A disease model initially dominated modern treatment and eventually this spread, in one shape or another, to most areas of the world (Thom, 2001). The initial popularity of the disease model may be attributed to the influence of Alcoholics Anonymous and also to the work of Jellinek (1960) who developed the conception of alcoholism as a permanent, irreversible disease, by which he meant that alcoholics are persons (different to non-alcoholics) who experience an irresistible *physical* craving for alcohol, as a result of which they develop a *loss of control* over drinking and a consequent inability to stop that can only be overcome through abstinence. Through his work with the Yale Centre for Alcohol Studies and with the World Health Organization and his involvement with the *Quarterly Journal of Studies on Alcohol*, Jellinek had considerable international influence in promoting professional and lay interests around the issue of alcohol (Thom, 2001). In due course others elaborated on the disease model (American Psychiatric Association, 1968; Sellman, 1994; World Health Organization, 1967), bringing it to higher

levels of sophistication, and it was also extended to drug addiction, pathological gambling and other habitual behaviours and disorders.

2.2.2 Although the disease model initially attracted medical and scientific support, its spread and endurance can be attributed to more practical reasons (Thom, 2001). In popular discourse the disease model helps provide a distinction between on the one hand persons who are considered to take alcohol for social or recreational purposes, categorised as normal drinkers, and on the other hand, those, variously described as alcoholics, addicts, or alcohol dependent. The distinction underlines an assumption that views the latter as the *sole* group – usually out there somewhere - at whom treatment services should be directed. The notion that only certain individuals with an illness or disease can have alcohol problems permits others – not carrying this disease – to drink excessively and/or to generate demands for a relaxation of alcohol controls (Makela, *et al.*, 1981). The notion is certainly eagerly embraced by the drinks industry who draw comfort from the contention that alcohol problems lie with some individuals and not with alcohol (Morgan, 1988).

2.2.3 The idea of a distinction between alcoholics and normal drinkers can also suit agencies and personnel involved with treatment systems, as a narrowly defined group can demonstrate common needs and respond to prescribed interventions, thus potentially simplifying the task of mobilising treatment personnel, developing specialised programmes, organising these into professional and administrative structures and raising finance. It is quite common therefore for highly focused bodies such as private hospitals or not-for-profit agencies to develop and structure treatment provision around a disease model. An example of such agencies are concept houses such as Hazeldene or Minnesota Model whose approach has been used in the development of a number of treatment agencies in Ireland, three of which are located in the south east region.

2.2.4 The principal focus of disease-oriented treatment agencies is interventions designed to facilitate a person's recovery from an illness or disease: the model sees abstinence as the essential basis for *full* recovery. Treatment is commonly organised through an intensive post-detoxification, 4-6 week residential treatment (or combined hospital detoxification and residential) during which the resident is introduced to the idea of addiction as an illness, confronted with the effects of their addiction on others, and assisted in developing a commitment to the AA / NA twelve steps programme of recovery. The residential treatment component is usually followed by a long period of AA / NA attendance. Although this is often described as *aftercare*, AA / NA in fact operates independently of treatment providers and is thus available to persons whether or not they participate in professional treatment. Although disease-oriented treatment services tend to operate from a residential model they sometimes also provide services on a non-residential day-programme, basis.

2.2.5 Throughout the 1960s the disease model had popular application in many alcohol treatment systems, including in Ireland, but before long an expansion in research cast serious doubts on its theoretical and empirical foundations (Heather & Robertson, 1981; Institute of Medicine, 1990). Despite many critiques, however, the model has endured and continues to dominate US-based treatment systems. Also, many Irish treatment systems – drawing their influences from US rather than European drug and alcohol conceptions - continue to be dominated by the disease model (Butler, 2002), a fact that may be considered as impeding the implementation of a broader, public health approach, which is now discussed

2.3 *Public health model*

2.3.1 Unlike the disease approach to alcoholism, the public health model of alcohol problems does not confine its concerns to persons who fit a specific, clinical diagnosis, nor indeed does it offer an absolutely clear problem definition. The model draws from two separate, but related, developments in the field of alcohol science. First, is the development of the idea of *alcohol dependence as a syndrome* alongside the idea of *alcohol-related* social, psychological and physical problems, and second is the *broadening of alcohol policy* towards prevention and early intervention.

2.3.2 The idea of alcohol dependence as a syndrome was first aired in the 1970s (Edwards & Gross, 1976). In this conception, alcohol dependency arises from an interaction between biological processes and social learning. It is argued that the continued compulsion to take alcohol does not reside solely in biological processes although, in particular instances, these may have been set in motion as reactivity to alcohol. Learning processes are also involved in developing the compulsion to take alcohol such that an individual's expectation of discomfort arising from the absence of alcohol can in fact stimulate the desire for further alcohol. Over time compulsive drinking behaviour is reinforced through both social and psychological stimuli. A *sense* of loss of control can inevitably emerge alongside a clustering of other signs and symptoms that need not all be simultaneously present, nor is the presence of some of these symptoms always evidence of dependence.

2.3.3 Alongside the idea of alcohol dependence syndrome there is also the idea of *alcohol-related disabilities*, including physical (liver cirrhosis, cancer, cardiovascular disease and foetal alcohol syndrome), psychological (depression

and anxiety) and social (alcohol-related road injuries, violence, domestic problems, homelessness, workplace problems) (Edwards, et al., 1977). The idea of alcohol-related disabilities (more often referred to as alcohol-related problems) introduces a grey area between those whose alcohol problems include that of dependency and those who have other serious problems but who are not dependent. These conceptions of alcohol dependence and of alcohol-related problems suggest that alcohol problems are often best perceived as heterogeneous or as on a continuum from mild to serious with multiple dimensions to these problems at any single level (Institute of Medicine, 1990). The thrust of this approach therefore is to direct interventions at larger populations of heavy drinkers primarily rather than at sub-groups with problems of addiction or dependency only. This approach was also subsequently adopted in relation to drug problems with the use of the terms *problem drug taker* and *problem drug user*.

- 2.3.4 This dual approach towards both problems of dependency and other alcohol-related social, psychological and physical problems is consistent with a public health discourse derived from three major alcohol policy research projects over the last 30 years (Bruun, *et al*, 1975; Edwards, *et al*, 1994; Babor *et al*, 2003). These WHO-sponsored projects involved cross-national collaborations of authors / researchers drawn from health, social and behavioural sciences who conducted in-depth literature reviews and statistical reporting of selected themes, drawing from epidemiology, sociology and health economics. The reports assert *inter alia* that alcohol problems, which are considered to be both prevalent and preventable, affect the whole range of drinkers and not just those considered to be alcoholic (i.e. addicted or dependent) and also contend that societies can reduce their drinking problems through measures that restrict and reduce consumption (i.e. regulating to limit physical and economic availability) while also focusing on problematic drinking patterns (such as binge drinking) and hazardous drinking environments

2.3.5 These reports set the main public health policy framework for dealing with alcohol-related problems both internationally (WHO, 2000; WHO, 1996) and in Ireland (Department of Health and Children, 1996; 2004). A comprehensive update of this framework is provided by the third WHO report (Babor, *et al*, 2003), which also draws from epidemiological research to report on alcohol's 4% contribution to the global burden of disease (9% in western developed countries). In its review of policy measures, the report applies an evaluation assessment in which it rates seven separate broad sets of prevention and intervention strategies according to their evidence of effectiveness, their breadth of research support and their cost to implement and sustain. Measures considered to be achieving highest evaluation standards include taxation and pricing and regulating physical availability. Education, persuasion and regulation of alcohol promotion achieved a relatively low evaluation standard. Treatment and early intervention achieved an average standard. None of the treatment measures considered achieved a high level of effectiveness and only brief interventions achieved a moderate level of effectiveness, with moderate costs. Costs of treatment are assessed as low (for self-help), moderate (for brief interventions) and high (for specialist alcohol treatment interventions).

2.3.6 This report's cautious evaluation of alcohol treatment and early intervention potentially casts some doubt on the efficacy of treatment, particularly given the seemingly superior value of taxation and other control measures. Despite these limitations the report is rather optimistic about the value of treatment, arguing that treatment needed to be considered within the context of a holistic model of prevention and whilst treatment responses are designed and directed with individuals in mind they potentially have wider impacts at community and population levels, including:

- raising public awareness about alcohol problems
- helping to set a policy agenda at national and community levels
- involving health professionals in prevention roles

- providing supports to families
- providing secondary benefits to other community members such as employees and car drivers.

2.3.7 Furthermore, the report highlights that in countries with relatively well-developed treatment systems, treatment potentially has aggregate impact on alcohol-related problems. In this regard they advocate the need for comprehensive treatment systems, developed within public health models. It is important to note however that research on well-developed treatment systems highlight that these systems usually only attract into treatment a small proportion of persons who seek help, many of whom are more likely to seek help from primary and community care systems (Weisner, 2002). The successful development of comprehensive systems therefore rests greatly on their capacity to involve primary care and community and social services in providing interventions for drug and alcohol problems (Miller, 2002).

2.3.8 The value and efficacy of the public health model is that it allows for treatment across a range of problems. Treatment therefore can be understood as an intervention, or series of interventions, directed towards overcoming an individual's *problems of dependency* and / or other *problem drinking* or *problem drug-taking* and to develop their capacities to avoid relapsing to pre-treatment patterns of problematic drug and alcohol use behaviour. In the first instance treatment is provided in the form of early brief interventions (Bien, *et al.* 1993; Heather, 1995; 2001) and motivational interviewing (Miller & Rollnick, 1991). These interventions are focused on initiating intrinsic motivations to change and in bringing about changes in drug and alcohol behaviour prior to these becoming very serious. More intense treatment involves medical detoxification (if needed) in order to stabilise the individual combined with psychotherapy, social learning and education, which are designed to help re-focus the individual towards a lifestyle where they are abstinent or no longer reliant on drugs or alcohol or where

they have managed to reduce or control problems arising from drug and alcohol use (Marlatt, 1998).

2.3.9 The locations for providing treatments are in community, outpatient and residential settings. Community settings are less costly and also offer the best prospects of attracting into treatment persons whose problems do not prevent them from full normal functioning, thus it does not become necessary for such persons to cease working or to move away from their families. Community settings are also the preferred locations for socio-environmental interventions (George & Tucker, 1996) such as self-guided change (Sobell & Sobell, 1993) cognitive-behavioural therapy (Jarvis *et al.*, 1995) and community reinforcement approach (Meyers & Miller, 2001). The provision of treatment in an intense manner can require periods of regular attendance, where stabilisation can be achieved in comfortable surroundings, where distractions into drug or alcohol use are minimised and where psychotherapy and education can be administered with such attentiveness that their effects are profound and long lasting. In some instances, such as when a person lacks social and family supports or has a history of post-treatment relapse or in cases of acute psychiatric disorder, the provision of intensive treatment in residential settings is indicated. As with many other non-acute medical problems however, in the majority of cases, treatment can be administered on an outpatient basis and in community settings in order that there is a minimum of disruption to a person's family and work routines.

2.4. SUMMARY

2.4.1 There are two broad models for the treatment of drug and alcohol problems: a disease model and a public health model. The disease model essentially suggests that addiction is a unitary disorder, which is primarily explained by individual

vulnerabilities or predispositions in some drinkers and drug users. It also suggests that the disorder is unlikely to be influenced by broad prevention measures such as changes in population drug and alcohol consumption habits. For the health service its main implication is that service providers should create services – mainly of a specialist nature – that would resolve to cure or overcome this disease.

2.4.2 The public health model identifies a spectrum of acute and chronic social and health problems caused by drug and alcohol consumption, with dependence being just one contributory element to this spectrum. It emphasises the causal links between changes in consumption rates and patterns at population levels, which suggests strongly that health authorities should be concerned with prevention and health promotion. The model also broadens the base of treatment: in other words it argues for a role for all health and social service systems – including generic or primary care professionals – in managing these problems.

3 DEVELOPMENT OF POLICY ON ALCOHOL AND DRUGS

3.1 *Policy developments - alcohol*

3.1.2 Following the conception of alcoholism as a disease, and the development of a strong social movement in support of this conception, medical and health insurance systems during the 1960s found new opportunities to enter the field of treatment, which expanded greatly at the time, including in Ireland. This expansion was led initially by private hospitals and institutions and followed by public bodies often on the basis that treatments provided to persons who could afford insurance should not, in principle, be denied to those who relied on public health care. There was also, during the period, an increase in alcohol consumption and related problems, alongside more acceptance of psychiatry as a treatment for alcohol problems and an increasing public expectation that these problems could be “cured” through treatment (*Report of a Study Group on the Development of the Psychiatric Services, 1984* – commonly referred to as *Planning for the Future*).

3.1.3 In 1958 there were 644 admissions to Irish psychiatric hospitals with alcohol disorder as primary diagnosis, representing 5% of total admissions. Throughout the 1960s and 1970s there was a dramatic increase in such admissions and these peaked in 1979 at 7,158, or 26% of all admissions. This level of admission continued throughout the 1980s and eventually began to decline, in keeping with an overall decline in psychiatric admissions, during the 1990s (*Ibid.*).

3.1.4 Arising from the expansion of hospital admissions for alcohol treatment – and possibly even alarmed by it - chapter 13 of the report, *Planning for the Future*,

(*Ibid*) published 20 years ago, advocated a radical overhaul of the alcohol treatment system. The report was influenced by the emerging public health model and par. 13.2 discussed the nature of alcohol problems as follows:

Until recently, the generic term ‘alcoholism’ has been used to refer to a variety of problems resulting from alcohol abuse. However, because the word is difficult to define satisfactorily and because it suggests a particular type of alcohol problem to the exclusion of others, it is limited in what it covers. The term ‘alcohol-related problems’, although more cumbersome, is more accurate. This term acknowledges that alcohol can cause, or at least contribute to, an assortment of social and physical problems, which include public drunkenness, family violence, absenteeism, road traffic accidents, liver and heart disease, and disorders of the central nervous system. (p.104)

3.1.5 There were two key components to the radical overhaul of services as proposed by *Planning for the Future*. First, the report challenged the wisdom of trying to treat and manage alcohol problems through costly in-patient care arguing that there was no evidence of it being any more effective than community based care and also arguing that the intensive, specialist approach draws the problem away from the community, thereby excluding primary care and community medical and social services from having a role and input. The report recommended that as far as possible these problems needed to be dealt with “at a community level by the primary health care and social services” where the response can be earlier, where it can “take into account all aspects of the drinker’s immediate environment, including his family” and where the response can “be comprehensive in its scope”(p.109).

3.1.6 Second, the report recommended the need for a local alcoholism service to continue to have some specialisation in the field of alcohol-related problems. It advocated that each psychiatric service sector develop such a service and that it have a major emphasis on out-patient treatment, with access to a small number (2-

3) beds in circumstances where out-patient treatment is not possible because of distance or social reasons. The report suggested that a consultant in each hospital catchment area take special responsibility to organise and develop these services and that the services would become a resource for alcohol problems to primary care personnel, other community personnel and voluntary and self-help agencies.

3.1.7 The report also suggested that voluntary agency services should be integrated with local health board and that there was a lot of scope for voluntary agencies to develop responses at local level that took account of the broadly-based approach to prevention and treatment.

3.1.8 *Planning for the Future* could be considered as ahead of its time in terms of its analysis and proposals for service development. However, it had a number of deficiencies in spelling out the detail as to how these developments could be implemented. The report mentions “alcoholic counsellors” in describing some of the educational work that local services should be involved with but it makes no reference to the likely staff knowledge, skills and competencies that would be required for local alcohol services other than to identify the overall role of a consultant psychiatrist. Section 5 provides further discussion of some of the report’s shortcomings.

3.1.9 The *Green Paper on Mental Health, (1992)* commented that some health boards had proceeded to develop alcohol services through the recruitment of addiction counsellors to work in sector teams but again there was no detailing of the work of these counsellors or in what way they constituted either part or all of local alcoholism service provision as proposed in *Planning for the Future*. The *Green Paper on Mental Health* noted the continuing high level of hospital admissions for alcohol-related disorders and suggested that it was necessary to develop alternative, community treatment facilities.

3.1.10 The *National Alcohol Policy (1996)* noted that while *Planning for the Future* had recommended that local services be developed through psychiatric sector teams, in practice some health boards had gone this route while others had recruited counsellors through community care services. The report recommended that either arrangement was possible provided there was liaison between GPs, the local service and psychiatric service and that the responsibility for the development of alcohol services in the catchment area or community was clearly defined. However, like previous reports the *National Alcohol Policy* expressed concern about the continued high rate of hospital admissions and that these demonstrated the need to develop alternative, out-patient treatment facilities in the community.

3.1.11 The *Strategic Task Force on Alcohol - Second Report, 2004* (Department of Health & Children, 2004) in its discussion and recommendations on treatment emphasised the necessity for early intervention. It recommended the development of a national screening protocol for alcohol to be used in primary care, community medical services, hospitals (including A & E) and community-based programmes for vulnerable youth. The report also recommended that third-level colleges and workplaces develop appropriate policies and procedures for addressing alcohol-related problems. On the issue of location of specialist alcohol services the report recommended that each region provide a range of services that are “effective, accessible, appropriate and integrated with other services” that they have explicit pathways of care and that greater awareness of where people can obtain services be promoted.

3.2 *Policy developments - drugs*

- 3.2.1 *Planning for the Future* underlined the importance of social factors in relation to drug problems and that these problems may be symptomatic of “multiple community difficulties and disadvantages”. As with alcohol problems, the report queried the value of specialist, in-patient services and it advocated that the approach to treatment should be community-based with inputs from health and social service personnel, probation services and Gardai. The report did not spell out a role for sector psychiatric services in treatment although it did advocate that these services develop a role in prevention. Out of concern that opiates and other dangerous drugs prescribed for drug treatment could potentially be leaked into illicit markets, the report argued against the involvement of GPs in the treatment of drug dependence. At the time the report was issued drug treatment services were dominated by a disease model of addiction as outlined in section 2 above, a situation that continued for the next seven years or so, even though the public health model seemed to be more favoured by *Planning for the Future*.
- 3.2.2 The *Government Strategy to Prevent Drugs Misuse* (Department of Health, 1991) emphasised the necessity of involving GPs in a harm-reduction approach to the treatment of drug problems, particularly as a result of public health concerns in relation to blood-borne viruses, such as HIV. The report recommended the appointment or designation of health board coordinators of drugs misuse and the development of pilot community drug teams to coordinate and integrate treatment efforts at local levels. By focusing on issues of harm reduction and community-based services the report signalled a definitive move away from the disease model towards the public health model as outlined in section 2 above.

3.2.3 *The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996)* brought urgency to the need for a public health model and community-based drug treatment. It concluded that by far the greatest illicit drug problem in the country was caused by the use of heroin in a small number of disadvantaged areas, mainly in Dublin. It recommended multiple social, educational and environmental, as well as health interventions in the areas most affected, including the provision of community-based treatment through GPs, local centres, outreach and mobile clinics, an expansion in health board outreach and addiction personnel and the provision of funding support to community groups and user groups who were involved in rehabilitation. The report also recommended a coordinating structure for implementing the report consisting of a National Drugs Strategy Team and Local Drugs Task Forces (for 12 designated areas). Both structures drew in representatives from funding and implementation bodies. Community agencies were represented on local task forces. The report was published in conjunction with a government statement that contained funding commitments.

3.2.4 *The National Drugs Strategy, 2001-2008 (NDS)* (Department of Tourism, Sport and Recreation, 2001) constituted a consolidation of the 1996 report and was issued in the context of a commitment by the governments of EU member states to set out their national policies and priorities on drugs. The policy proposed developing the coordinating structures that were utilised as a result of the 1996 report by introducing a new coordinating structure at regional health board levels and through these structures to improve each of the region's overall capacity to provide community-based treatment and intervention, as required. Like the 1996 report, the NDS emphasised the importance of working with community groups and involving them in devising a range of different responses. During the preparation of this report the National Drugs Strategy Team convened a series of regional consultative public meetings. In the course of these meetings, particularly

those that were held outside of Dublin, including the south east, many contributors emphasised the need for a combined drug and alcohol strategy. While these contributions were widely commented upon, including by the Minister of State with special responsibility for the National Drugs Strategy at the time (Ryan, 2001), alcohol was not included in the new strategy when it was published. This *National Drugs Strategy* is currently (2004) undergoing a mid-term review.

3.3 *Summary*

3.3.1 Although developments in the practice of Irish psychiatric hospitals during the 1960s-1980s initially reflected the disease model, this approach lacked favour in the report, *Planning for the Future*, which was published in 1984. The report recommended a radical re-orientation of the alcohol treatment system and although it did not reference this as such, it is clear that its proposals are in line with the public health model, as outlined in section 2 above. The report queried the level of psychiatric hospital admission for alcohol problems and proposed the creation of an alternative community-based system of treatment arguing that these problems are often best dealt with in the context of community-based health and social services. The report also suggested that a specialist community alcoholism service should be developed as part of sectorised mental health teams. Subsequent reports in 1992 and 1996 noted that the main component of this new community-based system has been to develop addiction-counselling services. The *National Alcohol Policy, 1996* acknowledged that this counselling service could be organised administratively under either community care services or mental health services provided there was clear direction and coordination. The *Strategic Task Force on Alcohol (Second Report), 2004*, advocated the provision of brief interventions through a range of primary care, community care and general hospital settings. It also suggested that a range of specialist treatment services needed to be available within any particular catchment area.

3.3.2 Although drug treatment services were initially structured along the lines of a disease model, official reports have consistently advocated a broader, public health approach. *Planning for the Future* also advocated a community approach to drug problems although it did not support GP involvement in treatment. Subsequent health concerns about blood-borne viral infections arising from use of illicit syringes provided the main impetus for an investment in public health responses, with GPs having a central role in community treatment. The effect of opiate problems on particular communities highlighted the need for community services, community involvement in service planning and management and integrated structures for service development. Many aspects of this new model, which was developed in certain communities in Dublin, have now extended into regions. However, an expectation by bodies and personnel based outside Dublin that the new strategy should incorporate alcohol, as well as drugs, was not realised, although in some instances an integration of both continues to be pursued at local and regional levels.

4. PROGRESS IN POLICY IMPLEMENTATION IN HSE (SOUTH EAST)

4.1 *Policy progress – local drug and alcohol services*

4.1.1 Following *Planning for the Future* community alcohol counselling services were set-up in five (now four) areas in the south east under the direction of mental health services; consultant-led, and in the main linked to sector mental health teams. The focus of these services was counselling for persons treated within the mental health service with addiction problems and, in most teams, counselling for persons referred by other means (including self-referral). The services were assigned addiction counsellors, some of whom were recruited from an existing pool of ward-based psychiatric nurses: assignments that were made possible as a result of reduced requirements for ward nursing personnel. Some new counsellors undertook training by participating in a placement at Stanhope Street Alcoholism Treatment Centre, Dublin, which, at the time, operated a day centre that was based on the Minnesota Model (disease model) of treatment. In due course many counselling personnel also undertook the Diploma in Addiction Studies course at Trinity College Dublin, and other relevant courses, both at home and abroad.

4.1.2 At an early stage community addiction services developed a range of interventions and explored different methods of work in the context of developing outpatient programmes. They were also involved in preventive work through an engagement with GPs, other professionals and with schools and community / voluntary bodies. Over time however, it is suggested by counselling personnel involved, that limited resources and staff numbers meant that they had to focus their energies on providing individual counselling services, both within and outside hospital settings. This focus on individual counselling meant there was little opportunity or support to develop new community initiatives or programmes.

Indeed, there is a strong sense among counselling personnel that once the counselling services were set up and operating, there was little further attention to their planning, development and coordination. It was considered that the services lacked administrative or organisational back-up and in some instances counsellors undertook these tasks themselves, with the result that some personnel felt quite isolated. There is also a sense among counselling personnel that although the thrust of stated policy was to support an out-patient, community-based approach, the development of community services lacked serious investment, and this is contrasted to the level of investment made available to new residential services that were set up and operated by voluntary agencies.

4.1.3 Internally, there is, among practitioner and management personnel alike, a positive view about the level of progress made by these services. However, there is an absence of formal evaluation. Paradoxically, an attempt to develop supportive documentation through a review of services in one of the areas, Carlow / Kilkenny – the review was requested by practitioner personnel in the area - was perceived by some practitioners as generating unfair critical comment about the services in general. Aside from this report, there is a need to rely on the recollections of personnel who worked in the services in developing a picture of their progress and development and among personnel there is a strong sense that although a lot of progress was achieved, their work lacked the recognition they believe it had earned.

4.1.4 At a wider national level the development of such services may be characterised by: a lack of investment (resources, management expertise and professional development) in developing the alternative community-based treatment model that was envisaged, by a lack of engagement of primary & community care providers, and by the continued domination of residential treatment provision (Butler, 2002). This lack of progress at a national level can in part be explained by the poor state of public health finances at the time. It can also be partly explained

by the lack of policy priority and leadership given drug and alcohol problems, a priority that did not emerge until later years. When indeed these issues were given greater policy priority during the mid 1990s and since, the impetus for change came not only from a process of rational policy planning and development, but also from new community, social order and public health demands arising from the growing illicit drug problem and the related problem of HIV / AIDS. These problems had particular impact in disadvantaged communities, mainly in the Dublin area, and their seriousness prompted the government in 1996 to convene a high level ministerial task force to draw together an assessment of the problem and to make recommendations. This task force's conclusions set in train a radical new approach to the treatment of drug problems that in turn had impact on the treatment of alcohol-related problems also.

4.1.5 As outlined in section 3, the ministerial task force underlined the community dimension to serious drug problems and as a result of its recommendations local drug task forces were established in designated priority communities in Dublin (and one in Cork) and coordinating structures at national and regional levels were also established. New funding streams for tackling drug problems were developed and, unlike previous funding, these new streams established roles for community organisations and representatives in the development of new initiatives and services – in south east region for instance the health board funds the employment, by community agencies, of eleven community drug workers. As a result of these developments community groups had new forums for articulating their general concerns in relation to drug and alcohol problems and also for outlining specific criticisms of existing service provision, such as lack of provision for young people and the lack of adequate community service provision in relation to illicit drug problems.

4.1.6 In developing a response to increased external demand, HSE management, through the Regional Drug Coordination Office, which was created as a result of

developments in national drug policy during the late 1990s, set up an internal working group to deliberate on the future direction of addiction services within the health board. The thrust of this working group's recommendations (WGR) – which were adopted as health board policy – was to establish substance misuse teams in each of the now four areas, staffed by a local coordinator, an education / prevention worker and by community addiction counsellors. The recommendations envisaged that addiction counsellors who to date had operated in the context of mental health teams could in future operate within the overall context of new community teams. The proposals proved controversial. Although there is widespread support for the proposals' intentions to reach deeper into local communities, they generated considerable disaffection, which in due course led to the forum held in November 2003, subsequently leading to the production of this report. Issues concerning these proposals and their further development are discussed in section 5 below.

4.2 *Summary of relevant data from community addiction services*

4.2.1 Since 2000 the Regional Drug Coordinator's Office has published figures on the demand for drug and alcohol counselling services within the region. The discussion below on levels of counselling is based on 2002 figures (Kidd, 2003). Although 2003 figures are available it is more appropriate to use the former figures for the reason that 2002 hospital admission figures are also available (Daly & Walsh, 2003). These latter figures are also outlined and discussed below.

4.2.2 In 2002 sixteen counsellors provided counselling services in both community addiction services (mental health) and community care services and in total 1,517 clients were seen through these services (Kidd, 2003). The following table represents the sources of referral for these counselling clients.

TABLE 1: Community services intake (2002)

<i>Source of referral *</i>	<i>% Referred from source</i>	<i>Estimate of persons referred from source</i>
Self, family friends	25%	380
Drug treatment services & hospitals	30%	451
Court/ probation / police	25%	380
GPs & social services	16%	239
Other	4%	67
Total	100%	1,517

* Kidd (2003)

4.2.3 The figure of 1,517 clients seen, in so far as it can, provides some indication of the level of counselling activity during 2002. From the table it can be seen that an estimated 451 persons were referred to counselling either by drug treatment centres or by hospitals. Although a satisfactory breakdown is not provided, it is likely that this group of persons also feature in psychiatric admissions or non-psychiatric residential admissions (see below). A further 380 persons were referred directly by courts / probation service. These would be formal, structured referrals where the referrer's intention would be to have an assessment or a report on counselling progress for the purpose of court deliberations in relation to criminal proceedings. An estimate of 686 persons, seen by the counselling service in 2002, was referred through self, family or friends, GPs & social services, or others. This figure of 686 (45% of total) in so far as it can, provides some indication of the level of counselling activity that takes place within the arena of community care / primary care, that is not linked in with residential treatment (both psychiatric and non-psychiatric) or courts / probation.

4.3 *A summary of relevant data from residential admissions*

4.3.1 The Health Research Board publishes in-patient admission figures for alcohol disorders annually. The current (2002) level of admission for alcohol disorders as a primary diagnosis is just under 4,000, representing 17% of total psychiatric hospital admissions (Daly & Walsh, 2003). As outlined earlier, at the time that *Planning for the Future* was compiled and published, the level of hospital admission for alcoholic disorder in Ireland was over 7,000 representing 26% of all psychiatric admissions. The new figures constitute a reduction of 43% on the 1980s figure. In 2002, 3% of national hospital psychiatric admissions had drug dependency as a primary diagnosis.

4.3.2 While psychiatric admissions for alcohol disorder have decreased over the last 15 years there has been an expansion in the provision of treatment places in non-psychiatric, residential units that use a Hazeldene / Minnesota Model for the treatment of addiction problems as a disease. The total annual figures on admissions to these units are not published but figures are available from three of the units operating in the south east region (Kidd, 2003). One of the units provides services to persons aged 15-21 years only. These figures along with figures of admission to hospital psychiatric services for both alcohol disorders and drug dependency are summarised in following table.

TABLE 2: Residential admissions (2002)

<i>Type of admission</i>	<i>Admissions for alcohol disorder</i>	<i>Admissions for drug dependence</i>	<i>Total admissions for drug and alcohol</i>
Hospital psychiatric admissions (adult) *	581	112	693
Non-psychiatric, residential admissions (adult)**	145	26	171
<i>Sub-total (adult)</i>	726	138	864
Non-psychiatric residential admissions (adolescent – 15-21 yrs)**	22	18	40
TOTAL	748	156	904

*Daly & Walsh (2003) ** Kidd (2003)

The 2002 hospital admission figures for alcohol disorders in the south east region are 581 representing 19% of all admissions in the region. Regional admission figures for drug dependency for 2002 are 112, representing 4% of all admissions. In addition, a total of 211 persons (171 adults; 40 adolescents) were admitted to non-psychiatric services for both alcohol (167) and drugs (44). Combining the *adult* figures with alcohol psychiatric admissions yields a total of 726 residential admissions for the region, of which 20% are admissions to non-psychiatric residential units. While there is a likely double counting in these figures as many new admissions to non-psychiatric units are first admitted for hospital detoxification, the combined figures provide a better picture of the overall demand for residential treatment than does the published figures for hospital psychiatric admission. Combining the *adult* psychiatric hospital admissions and non-psychiatric admissions for drug dependency yields a total of 138 adult residential admissions for drug dependency, with non-psychiatric admissions accounting for 19% of total. The combined total of all adult admissions is 864 and the combined total of all admissions (adult and adolescent) is 904.

4.4 Conclusion

4.4.1 Arising from *Planning for the Future*, community alcohol services were set up in each of the south east areas. There was initial enthusiasm for the development of these services and practitioner personnel were involved in developing a range of different programmes and initiatives. In due course however, it became apparent that the services, as with similar services in other regions, lacked overall developmental support and resources and also lacked formal evaluation or acknowledgement. In recent years, they have also had to face up to new challenges arising from an escalation in illicit drug problems and changing expectations from the community as to the role and function of community drug and alcohol services. Against this background, the health board has undertaken a number of initiatives aimed at improving and consolidating the provision of local services. These developments envisaged that the core of new service development would be community-based, substance misuse teams and that existing counselling personnel could in the future operate in the overall context of these new teams. However, outstanding matters concerning the respective functions and responsibilities of these teams and counselling personnel who are based in mental health teams continue to require further clarification.

4.4.2 In conjunction with setting up new teams the health board, through its Regional Drug Co-ordinator's Office, has also since 2000, collected data on attendances at drug and alcohol counselling services. This data is analysed for 2002. In all 1,517 clients were seen in this year: 451 (30%) referred through hospitals / drug treatment centres; 380 (25%) referred through courts & probation; and, 686 referred through other community, primary care and self-referral sources. The latter figure of 686 (45%), in so far as it can, indicates the level of community counselling activity, that is not associated with hospital / residential admissions or courts / probation.

- 4.4.3 The overall figure of admission for drug and alcohol dependency to *adult* residential units (psychiatric and non-psychiatric) in the south east region is 864 (726 alcohol; 138 drugs). In addition a further 40 (22 alcohol; 18 drugs) persons were admitted to adolescent treatment (ages 15—21), giving a total of 904 admissions. The figure of 864, in so far as it can, provides some indication of the level of residential activity associated with *adult* drug and alcohol problems in the region during 2002.
- 4.4.4 Although the above two sets of figures do not lend themselves to direct comparison it seems clear that the overall level of residential and institutional activity with respect to drugs and alcohol, is marginally greater than what is indicated for community and primary care services. Furthermore, it appears that community services are not directly involved with all of those admitted to hospital care.
- 4.4.5 The primary objective of *Planning for the Future* was the provision of mental health care based upon a comprehensive continuum of services and facilities, ranging from out-patient clinics and domiciliary visiting through acute admission units, day centres and long-stay hostels. It was believed that modern clinical practice and good quality patient care would be facilitated by a move from the traditional reliance on in-patient care, and it was envisaged that the implementation of this plan would result in a radical reduction in admissions. The overall significance of the above figures is that the objective of this proposed overhaul is not being fully achieved. It is clear that hospital admission remains a popular form of treatment and that the general popularity of residential-based treatments is reflected in the growth of non-psychiatric, residential treatment centres. It is also clear that while great effort, against difficult odds, has been made by the personnel concerned to develop community services, these services are not administratively integrated into an overall service plan aimed at reducing

inpatient admissions and at developing comprehensive, outpatient and community systems.

4.4.6 The continued high rate of alcohol admissions to intensive, inpatient hospital treatment is consistently queried in reports on activities of Irish psychiatric services indicating a concern that hospital admission is perhaps an over-used instrument. Certainly, during the compilation of this report, discussions held with management and professional personnel in two of the four south east areas, indicated that a considerable number of hospital admissions are inappropriate and often result from the excessive demands of prospective patients, their families or friends, public bodies or authorities, seeking quick “solutions” to crisis problems. These concerns add further to the proposition that health authorities should invest greatly in developing appropriate community-based and outpatient services as alternatives to residential treatment.

5 OVERVIEW OF POLICY IMPLEMENTATION AND CHANGE

5.1 The report *Planning for the Future* is an important milestone in the development of Irish psychiatric services in general and drug and alcohol services in particular. In relation to these latter services the report advocated a major overhaul by recommending that such services be community based, primarily, and that in-patient residential services – which were not considered by the report to be any more effective than outpatient services – be used only sparingly. While some progress in relation to the achievement of this proposed overhaul is evident, it is clear, from the discussion above, that the envisaged service transformation did not occur. In general there continues to be a high utilisation of in-patient treatment facilities and community-based and outpatient services remain under-developed. Two questions arise in relation to the non-achievement of the major overhaul that was advocated by *Planning for the Future*. First, what are the main factors that underline it and second, what factors continue to prevent the HSE (South East) from achieving the level of community service provision that its personnel, practitioners and management alike, aspire to. The first question cannot be fully answered due mainly to the absence of prospective evaluation. The accounts of existing personnel are limited because of their retrospective nature, and, in any case, the accounts of persons, who have long since left the service, are missing. However, some exploration of this issue is helpful if only to provide an historical context for exploring the second question.

5.2 There is little doubting the ambition of *Planning for the Future*, in both a general sense and in terms of its specific recommendations in relation to alcohol services. Indeed it is clear that many practitioner personnel continue to express enthusiasm in relation to *Planning for the Future* and its aims and recommendations. However, from an implementation perspective *Planning for the Future* lacked a number of important ingredients. In proposing a new departure for alcohol

services it juxtaposed residential and non-residential services and advocated the primacy of the latter approach without debating these matters in any great detail. The report should perhaps have either envisaged the need for further debate of this issue, or provided more considered arguments on the respective merits and disadvantages of the different approaches. It seems clear, in retrospect, that among the general public and within services, health boards included, there was an enduring belief in residential forms of treatment, consistent with widespread support and enthusiasm for the disease model of treatment. It appears that many public expectations remain consistent with this view and that many of the assumptions about service developments that were underlined by *Planning for the Future* continue to require public explanation and debate.

- 5.3 A second ingredient lacking in *Planning for the Future* related to the strategies and procedures for managing policy change in health services. Policy change is a complex process and implementation does not follow a simple linear path, following through from policy decisions. The organisational dimensions to change cut across the whole system. Policy change can have potential impact at all levels of service delivery: policy / management; sector / community teams; and, individual practitioner levels (Burke, 2002; Coghlan & McAuliffe, 2003; Rashford & Coghlan, 1994) and policy implementation therefore, requires a focused approach to managing the change process at each of these levels. This did not happen with *Planning for the Future*. In the south east, as with other regions, it appears that the decisions to set up community alcohol services lacked an overall implementation or organisational strategy. At a national level there appears to have been no implementation plan, and at regional level there seems to have been little focus on the professional skills and competencies that would be appropriate for such services, or attention to the organisational, administrative and evaluative supports and resources that would be required. It appears that the policy as articulated in the report *Planning for the Future* was not adequately detailed nor properly understood at a number of levels within the health care

system, suggesting that the lack of implementation with respect to drug and alcohol services, and community alcohol services in particular, is a system failure, that can be explained in part, as already mentioned, by a lack of adequate public finances and a lack of policy priority, during a critical period in the policy's development.

- 5.4 In moving forward to the second question posed above: - concerning factors that prevent health board personnel, practitioners and management alike, from achieving the level of service provision that they desire – it seems clear that two lessons can be learned from our discussion in the previous paragraphs. First, in order to move forward, there is a need to spell out proposed changes in a manner that distinguishes what is being proposed from what is already in place. Second, there is a need to undertake this task in a manner that explores the prospective changes that are needed at all levels of the implementation system – from policy, management, local and practitioner levels.
- 5.5 The decision by the HSE (South East) to initiate the process leading to the Working Group Recommendations (WGR) could be represented as a determination by health personnel to bring about a major change in the way in which drug and alcohol services were being developed. It seems clear that from the mid 1990s, with the development of new policies on illicit drug use, health board management decided there was a need to give more priority to drug and alcohol issues. The focus of new policies – and funding arrangements - on the community dimension to drug problems certainly helped both management and practitioner personnel to articulate the need for change. The determination to bring about change is evident from the support attained at Board level and by the number of personnel from a variety of perspectives who participated in the working group's deliberations and certainly, the working group's recommendations provide a basis for the comprehensive development of drug and alcohol services in the region. However, drawing from our discussion above, there

are a number of weaknesses within these proposals that need now to be outlined.

- 5.6 First, WGR does not provide an overview or analysis of existing service provision, so that it lacks a context for assessing the changes that are represented by its proposals. In the absence of this assessment it should be no surprise that most post-publication attention focused on the one change that seemed to have practical implications for at least some of the personnel concerned, that is the proposal that addiction-counselling staff would operate within the context of new substance misuse teams. It is unfortunate that so much attention has focused on this aspect of the document, especially as it seems that the broad thrust of its recommendations enjoy widespread support. In this regard, the discussion in sections 2, 3 and 4 of *this current report* may help fill the gaps left by the WGR.
- 5.7 Second, WGR focuses almost exclusively on proposals at practitioner and team levels and pays little attention to the need for change and developments at policy and managerial levels. As outlined above, the development and implementation of policy within any system requires changes at all levels. This is especially so in instances where failures throughout the whole system have brought about the need for change, as was the case with drugs and alcohol treatment policy. However, by focusing on change at practitioner and team levels, the WGR unintentionally suggests that it is at these levels that change is most needed. In the absence of a clear reference to the need for changes at other levels the WGR has left some personnel in these services lacking acknowledgement or affirmation for the work they had undertaken and the achievements that had been made. This needs to be corrected in the sense of a clear statement that acknowledges that any failure of achievement with respect to the development of community drug and alcohol services is primarily a failure across the health care and policy system and not a failure at the level of direct service provision. It also needs to be rectified by bringing forward proposals that relate to service development and change at all levels.

5.8 In addition to the above two weaknesses of WGR there is a third factor that has inhibited service development and this concerns the role of the *National Drugs Strategy* (NDS) in bringing about change. It is important to reference the role of the NDS with regard the health board's determination to bring about change. For a number of health board personnel – management and practitioners alike – the NDS constituted an opportunity to apply a strategic approach to developing local services. In addition to NDS's strategic coherence – it has five separate pillars: supply reduction, prevention, treatment, research and coordination – it also offered the prospect of new investment. The NDS is perceived as the main mechanism for bringing new funds into the addiction (drugs) field, funding that comes with the condition that there be greater emphasis in developing services through local structures and utilising community models. The NDS is also perceived as bringing a new and important focus on the needs of young people with drug and alcohol problems.

5.9 The NDS was and clearly is an important engine for funding new developments. By bringing a working group together and by developing proposals as outlined in WGR the health board believed it was acting in a manner that was consistent with extending aspects of the NDS into the region, thereby attracting new investment. However, there is a strong sense among some personnel that the NDS was represented as the main decider of change. This was difficult for people to absorb especially as some of the problems in the service pre-existed NDS and most of the problems, in any case, concerned the issue of alcohol, which was not part of the NDS's remit. Furthermore, many personnel express concern about the NDS's local coordinating structures which are perceived as having application in circumstances where there are high levels of opiate use, and related social problems, but not easily replicated for dealing with a more widespread alcohol problem. It is felt that a more open critique of NDS could have helped build broader support for the proposals for change contained in WGR.

- 5.10 As regards the future of addiction services there is at this stage a strong sense of frustration and fatigue with this issue and a desire that management make a very clear statement about the direction of change and remove the doubts and confusions that have existed now for some time. Before making recommendations for moving forward in this report, it is useful to draw from Miller's (2002) proposals on the main steps that need to be taken to develop integrated care systems for substance misuse. Miller is a renowned international expert on addiction treatment systems, and their outcomes, and his proposals are made in the context of a critical review of specialist treatment systems. It is also useful to draw from Blumenthal *et al's* (1993) framework for developing a comprehensive, integrated treatment system for drug and alcohol problems.
- 5.11 First, it is argued that a comprehensive, integrated system requires a clear sense of vision and direction and that there are in place executive and management structures capable of planning and delivering programmes that are consistent with this vision and of ensuring accountability and compliance with monitoring and evaluation. It is clear that successive Irish alcohol and drug policy documents favour a public health model, one that broadens the base of both treatment problems and treatment providers, although these are envisaged as separate models for drugs and alcohol. What is perhaps less clear is the mechanisms and structures that need to be in place to give effect to this vision, a confusion that is exacerbated by the separation of alcohol and drugs in policy terms and by the variability of implementation structures at local and regional levels. These are issues that need to be addressed in recommendations for moving forward.
- 5.12 Second, it is argued that persons who use the main health and social service systems need to be regularly and routinely screened for drug and alcohol problems. The overall prevalence rates of these problems are sufficiently high to warrant widespread screening and given that these rates are likely to be even

higher amongst persons who regularly attend health and social service systems, there is a compelling argument for introducing screening within these systems. Current policy on alcohol treatment supports this approach as is evident from proposals for developing a national alcohol screening protocol in *National Task Force on Alcohol (Second Report) (2004)*.

- 5.13 Third, a range of treatment services, with varying levels of intensity, corresponding to the severity of problems encountered needs to be available. This may be described as the stepped-care model as outlined by Sobell & Sobell (1993). Prospective clients need to be able to access those services that are most appropriate to their needs and to have a continuum of care according as their situation progresses or remits. In this sense treatment needs to be perceived not as a set of different treatment programmes but as a system with different treatment components, that could be provided by different agencies (voluntary and statutory) but have an overall coherence, a shared vision and direction and a common system for planning and development.
- 5.14 Fourth, the treatment system as a whole – as distinct to its different programmes – needs a coordinated mechanism for undertaking assessments and case management of clients. Prospective clients need access to the forms of treatment that are most appropriate to their needs in a manner that is consistent across the whole system. This suggests the need for a standardised assessment procedure and / or the creation of a single mechanism for case managing clients when they come into the system.
- 5.15 Fifth, specialist drug and alcohol services need to have both practical and visible linkages with other primary and community care service providers in health centres, social service agencies and in community settings. This approach has been continuously advocated by policy reports: most recently the Mental Health

Commission in its *Annual Report, 2003*, described as “appropriate” the movement of services for alcohol problems away from the “mental health services to less formal, community-based services” (Mental Health Commission, 2004). There needs to be ongoing opportunities for drug and alcohol personnel to work alongside community and primary care personnel, particularly in relation to providing brief interventions, organising home detoxification programmes, providing methadone programmes and organising short-term counselling and psycho-social interventions.

- 5.16 Sixth, it is argued that expanded education and training for health and social service professionals be provided on an ongoing basis. Perhaps most importantly this involves training personnel in screening and brief interventions, as it is clear that the earlier the intervention the more likelihood it is that these problems can be overcome.
- 5.17 Finally, the above comments in relation to the future of addiction services draw mainly from reviews of adult treatment systems. The need for adolescent treatment for drug and alcohol problems is increasingly represented as an issue in the region. There is currently no national policy or framework for the treatment of adolescent problems, although Action 49 of the *National Drug Strategy* (2000) promised that a framework would be in place by 2002. This new framework is currently in preparation. However, as an action under the *National Drugs Strategy* it is likely that the framework will be based on problem drug use alone, with little, if any reference to alcohol use / alcohol treatment. A comprehensive blueprint for developing adolescent substance misuse problems (drugs and alcohol) was developed in the UK (Gilvarry, *et al.*, 2001). Amongst other recommendations this document underlines the importance of locating adolescent interventions within the overall context of child welfare, child development and child and adolescent mental health and suggests that interventions be organised according to a four-tiered system, similar to the stepped-care model already referred to above.

6 RECOMMENDATIONS

- 6.1 First, both the *National Drug Strategy (2001)* and the *Strategic Task Force on Alcohol (Second Report) (2004)* together constitute a comprehensive blueprint for the development of drug and alcohol services. It is recommended that these strategies be integrated in the context of a single, public health model for dealing with substance misuse problems. In south east and other regions outside Dublin the methodologies and techniques for reducing the demand for illicit drugs are the same as for alcohol and it no longer makes practical or policy sense to continue separate policies and systems particularly now that many of the measures associated with the *National Drug Strategy* have been so successful. The HSE (South East) has adopted an integrated policy. It is recommended that this be retained and an integrated policy at national level be advocated.
- 6.2 Second, it is recommended that substance misuse services have executive management at the highest possible level in whatever regional structures that emerge through health services reorganisation. There is need for an executive manager with similar status of a programme manager, to negotiate and decide budgets and staffing requirements and make executive decisions for developing services, and to commission research and evaluation.
- 6.3 Third, it is recommended that alongside an executive manager that a consultant psychiatrist for addictions be assigned clinical coordinator for drug and alcohol services, either in a regional area or as one of a small number of responsibilities in sub-regional areas, depending on the structures arising from health services reform. In addition to providing clinical support to mental health and community service teams, the consultant psychiatrist would have policy and development functions, assisting addiction personnel to develop an overall vision for their work, supporting training and professional development, liaising with GP bodies

and other professional bodies and initiating and overseeing the development of screening, assessment and treatment protocols and more specific protocols for dealing with substance misuse and co-related psychiatric disorders.

6.4 Fourth, it is recommended that area treatment systems be re-structured to fully operate a stepped care model whereby persons are assessed and assigned to modalities of treatment intensity that are appropriate to the severity of their problems. It is further recommended that in order to give effect to this proposal that the following key service components – which are detailed in an appendix - be developed in each county / community care area:

- intake / assessment community team (also providing brief interventions and maintaining and coordinating case management for all persons who enter the treatment system)
- outpatient treatment facilities (including short-term psycho-social and educational programmes and more prolonged relapse prevention programmes)
- inpatient treatment facilities (short-term, intensive treatment).

6.5 Fifth, it is recommended that the work of the drug education officer be expanded to increase in-service training for personnel at all levels of the service system, thus ensuring not only that there is an upgrading in relevant knowledge and skills but also that there is a better understanding overall of the treatment system, of its aims and objectives, its potential and limits and its various procedures for operating on a day to day basis. It is also recommended that more attention be given to helping the public understand that there is a broad array of drug and alcohol problems and a greater number of people need to deal with these problems even though they may not be chronic users or dependent.

- 6.6 Sixth, it is recommended that a protocol for screening for drug and alcohol problems with persons attending relevant agencies and professionals in health and social care be developed. With the development of a screening system there is also a need to develop a research protocol in order to improve epidemiological reporting of drug and alcohol problems.
- 6.7 Seventh, it is recommended that child welfare, child development and child and adolescent mental health services be brought together alongside substance misuse services and relevant youth services to devise an appropriate regional framework for the provision of substance misuse services to adolescents that reflects the four-tiers model as outlined in the UK report, *The Substance of Young Needs*.

APPENDIX

STEPPED CARE MODEL

The stepped care model is based on the idea that the intensity of treatment intervention offered to persons who present with drug and alcohol problems should reflect the severity of their problems. For example, on the one hand persons with mild to moderate drinking problems would benefit from brief interventions, consisting of practical advice and information, while on the other, persons with serious dependency problems or who lack social, family or material supports and / or who have co-related psychiatric disorders, would benefit from more intense treatment, either outpatient or inpatient, depending on the severity of the problem.

The following factors are key in the operation of a stepped care model:

- 1 Treatment is offered not simply on the basis of accessing a specific service or intervention but on accessing a treatment system.
- 2 The treatment system needs to have a standard mechanism for facilitating referral into the system, and standardised assessment
- 3 The treatment system needs to assign keyworkers / caseworkers who continue to assess and monitor a person's progress within the system.
- 4 The treatment system needs to have a set of separate programmes that vary in intensity according to the severity of presenting and continuing problems and with their use of therapies and other techniques, but must maintain an overall consistency with the treatment system's aims and objectives.
- 5 The treatment system needs to have strong relationships with various bodies, institutions, professionals and voluntary and community organisations that

operate outside of the system and who potentially can refer into the system and / or receive referrals out of the system.

The following table summarises levels and interventions within a treatment system.

Level	Interventions
<i>Self-change</i>	No intervention – availability of information
<i>Assisted self-change</i>	Brief advice intervention, encouragement to participate in self-help groups or to link in with community / voluntary project, GP or other community-based projects / personnel
<i>Community care / primary care: psycho-social programme</i>	Short-term counselling intervention, integrated with advice / information on co-related issues (housing, finance, employment, education, relationships, etc) + detox and medical intervention (e.g. methadone programmes), as needed.
<i>Specialist, outpatient intervention</i>	Daily (or 2-3 times per week) attendance for pre-designed, short duration programmes, drawing from best evidence, (behaviour, social learning, community reinforcement) + detox and medical intervention (e.g. methadone programmes) as needed.
<i>In-patient treatment</i>	Intensive, residential, pre-designed programme combined with detox (or maintenance) as needed.

These treatment levels are not as easily differentiated as may appear in the table above. Obviously it would be necessary to develop a system of information that would allow for this differentiation and in due course much of this information would be derived from caseload practice and management.

To develop and implement this model in the south east region it is proposed that the following key components need to be put into place, in each of the community care areas:

- intake / assessment community team
- outpatient treatment facilities
- inpatient treatment facilities.

Intake / assessment community team

Each community care area should have a core team of drug and alcohol caseworkers / counsellors who would provide outreach contact, intake assessment, who would intervene as appropriate at the lower levels of treatment intensity and who would continue to function as a keyworker or case coordinator in circumstances where a person remains in the treatment system, at other levels. It would be envisaged that this team of caseworkers have facilities for conducting assessments with persons who either

- (1) self-refer (walk-in) on the basis of self-identification problems, or
- (2) are referred by professional personnel in community or primary care settings.

Assessment would involve enquiring into drug and alcohol use (CAGE or AUDIT - where this has not already been used) to establish whether a problem exists and whether further assessment is necessary ; the provision of a brief intervention where early stage, mild to moderate problems are indicated, or if the problem is more serious taking a full alcohol and drug use history (Addiction Severity Index), and a social history and assessing entry to short-term psychosocial programme and /or referral to GP for home detox, or referral to higher level of intensity service

The essential idea of a walk-in advice service is that persons who are in distress or who have become concerned about their problems would be able to access advice, counselling and / or assessment within a short period of requesting it. This service would need to be provided in both daily (weekdays 9-6) and after-hours formats. The clinics would need to

be at different locations and the number of clinics and locations would develop and expand according to the needs and demand of areas. Each location would have its own receptionist / reception area, perhaps shared with other users of the same facility. It would be particularly important that any request to the service system for an intervention be channelled through this intake team although protocols would need to exist whereby each service component can deal effectively with crisis admissions or admissions for co-related disorders. Effective coordination could be developed through an after-hours and on-call dimension to the intake service.

Although the team would undertake most of their work in different community locations it is also important that they be assigned a specific community base in which they can assemble as a team and undertake administrative and other organisational duties relating to their work. Ideally this community base should be located as part of or adjacent to existing community care services. In addition to having easy access to primary care and community social services, such co-location would also assist in the much necessary mobilisation of natural community supports and resources in promoting self-change, assisted self-change and in developing community-based psycho-social programmes.

Team members would allocate clients for short-term interventions on a team basis, although it would be expected that in most instances, where indicated, a short-term intervention would be provided and managed by the same intake person. Short term interventions are possibly best structured around motivational enhancement techniques and indeed, keyworkers should continue a role in motivational enhancement with their clients that enter other programmes at higher levels of intensity.

As an intake team would be likely to operate in a variety of different settings, albeit with the same assessment / intervention protocol, it is suggested that the team have a diverse range of staff skills and competencies. It would be particularly important that the team

draw in personnel from social work / youth services in addition to addiction counsellors / health care workers.

It would be important that the service have a social worker assigned to deal specifically with cases involving child welfare issues. It would also be important that the team be assigned a liaison professional from mental health services to facilitate assessment and / or intake to the mental health system, where co-related psychiatric problems are indicated, as appropriate.

In addition to their work in undertaking assessments, short-term interventions and as case keyworkers, members of the intake team would obviously have a role in developing relationships and networking with primary and community care personnel, promoting screening and brief interventions, and explaining the overall functioning of the drug and alcohol treatment system. They would obviously also need to be involved with personnel at the next two levels of intervention: outpatient specialist and in-patient specialist.

Each intake / assessment community team would have a team leader who would provide guidance, leadership and clinical direction to the team. This should involve one to one supervision of individual cases as well as direction in relation to other aspects of the work, for example linking in with community bodies, with other professional groups, developing assessment skills, procedures etc.

Outpatient treatment facilities

There is a need to invest in the development of specialist, day programmes (that involve daily or regular attendance) for persons with drug and alcohol problems. Such programmes could be provided either directly by health board personnel and in health board premises, or alternatively by way of contract to external, not-for-profit bodies. There is little doubting that voluntary organisations can bring an important vision and

mission to the development of such programmes. They can bring a measure of flexibility that often assists attending persons in their adaptation to treatment and in treatment compliance. Already, residential treatment is provided through Aiseiri and Aislinn in this manner. Day programmes could be of a variety of types incorporating educational, vocational elements as well as psychotherapy. It is important that such programmes draw from evidence of best practice in their planning and in this context it is suggested that particular attention be given to programmes that are based on social skills development, cognitive – behavioural therapy and community reinforcement therapy.

It is suggested that the health board management invite proposals, both internally and externally, for the development of such programmes on a county / community care basis.

Finally, it is particularly important that the probation service / courts are drawn into the funding and development of such programmes. There is currently a significant draw from these agencies on the addiction counselling service. This needs to be more streamlined and there is also a need for a proper contractual relationship with these agencies in relation to the services provided.

Inpatient facilities

It is clear that the health board has a substantial current capacity for in patient treatment both in mental health services and through non-psychiatric services operated by voluntary bodies. It is important that these services not be perceived as separate to outpatient and short-term interventions. Rather in-patient services need to be seen as an important stage for the treatment of persons who have not been able to respond to non-residential treatments or whose problems are particularly severe. All inpatient and residential facilities need to be planned, developed and monitored in the context of consistency with overall policy and a continuum of care, and with adequate mechanisms and protocols to achieve integration with outpatient and intake services.

REFERENCES

- American Psychiatric Association (1968) (2nd edition) *Diagnostic and Statistical Manual of Mental Disorders*, Washington, DC: Author.
- Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Osterberg, E., Rehm, J., Room, R., Rossow, I. (2003) *Alcohol: No Ordinary Commodity. Research and Public Policy*, Oxford: Oxford Medical Publications.
- Bien, T., Miller, W., Tonigan, J. (1993) "Brief interventions for alcohol problems: a review", *Addiction*, 88, 315-336.
- Blumenthal, L., Hunter, F., Sawka, E. (1993) "A comprehensive and integrated system for treating alcohol and drug problems in Alberta" in J. Baer, G. Marlatt, R. McMahon (eds.) *Addictive Behaviours Across the Life Span: Prevention, treatment and policy issues*, London: Sage.
- Bruun, K., Edwards, G., Lumio, M., et al. (1975) *Alcohol Control Policies in Public Health Perspective, Helsinki: The Finnish Foundation for Alcohol Studies*
- Butler, S. (2002) *Alcohol, Drugs and Health Promotion in Modern Ireland*, Dublin: Institute of Public Administration
- Coghlan, D, McAuliffe, E. (2003) *Changing Healthcare Organisations*, Dublin: Blackhall Publishing
- Daly, A., Walsh, D. (2003) *Activities of Irish Psychiatric Services, 2002*, Dublin: Health Research Board.
- Department of Health (1996) *National Alcohol Policy, Ireland*, Dublin: Author
- Department of Health and Children (2004) *Strategic Task Force on Alcohol*, Second Report, Dublin: Author.
- Department of Tourism, Sport & Recreation (2001) *Building on Experience: National Drugs Strategy, 2001-2008*, Dublin: Stationery Office.
- Edwards, G., Anderson, P., Babor, T. F., et al. (1994) *Alcohol Policy and the Public Good*, Oxford: Oxford University Press
- Edwards, G., Gross, M., Keller, M., Moser, J., Room, R. (eds.) (1977) *Alcohol-Related Disabilities, WHO Offset Publication, No. 32*, Geneva: World Health Organization
- Edwards, G., Gross, M. (1976) "Alcohol dependence: provisional description of a clinical syndrome", *British Medical Journal* i, 1058-61.
- First Report of Ministerial Committee on Measures to Reduce the Demand for Drugs* (1996), Dublin: Stationery Office.
- George, A., Tucker, J. (1996) "Help-seeking by problem drinkers: social concepts", *Journal of Studies on Alcohol*, 57, 449-457.
- Gilvarry, E. (2001) (lead ed.) *Review 2001: The Substance of Young Needs*, London: Health Advisory Service (available [ww.dpas.gov.uk](http://www.dpas.gov.uk))
- Heather, N. (1995) "Brief intervention strategies" in R. Hester, W. Miller (eds.) *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* (2nd ed.), Needham Heights, MA: Allyn & Bacon
- Heather, N. (2001) "Brief interventions" in N. Heather, T. Peters, T. Stockwell (eds.) *International Handbook of Alcohol Dependence and Problems*, New York: Wiley.
- Heather, N., Robertson, I. (1981) *Controlled Drinking*, London: Methuen

- Institute of Medicine (1990) *Broadening the base of treatment for alcohol problems : report of a study by a committee of the Institute of Medicine, Division of Mental Health and Behavioral Medicine*, Washington, DC: National Academy Press.
- Report of a Study Group on the Development of the Psychiatric Services (1984) *The Psychiatric Services: Planning for the Future*, Dublin: Stationery Office
- Green Paper on Mental Health* (1992), Dublin: Stationery Office.
- Jarvis, T., Tebbutt, J., Mattick, R. (1995) *Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide*, Chichester: Wiley.
- Jellinek, E. M.(1960) *The Disease Concept of Alcoholism*, New Haven, Connecticut: Hillhouse Press.
- Kidd, M. (2003) *Drug Coordination Overview of Drug Misuse 2002*, Waterford: South Eastern Health Board.
- Makela, K., Room, R., Single, E., Sulkunen, P., Walsh, B. (1981) *Alcohol, society, and the state, Vol. 1: A comparative study of alcohol control*, Toronto: Addiction Research Foundation.
- Marlatt, G. (ed.) (1998) *Harm Reduction: Pragmatic strategies for managing high-risk behaviours*, New York: Guilford press.
- Mental Health Commission (2004) *Annual Report, 2003*, Dublin: Author.
- Meyers, J., Miller, W. (eds.) (2001) *A Community Reinforcement Approach to Addiction Treatment*, Cambridge: Cambridge University Press.
- Miller, W. (2002) "Is 'treatment' the right way to think about it?", in W. Miller & C. Weisner, *Changing Substance Abuse Through Health & Social Systems*, London: Kluwer Academic / Plenum Publishers.
- Miller, W., Rollnick, S. (1991) *Motivational Interviewing: Preparing People to Change Addictive Behaviours*, New York: Guilford.
- Morgan, P. (1988) "Power, politics and public health: the political power of the alcohol beverage industry", *Journal of Public Health Policy*, 9, 177-97.
- Ryan, E. (2001) (foreword by Eoin Ryan TD, Minister of State with special responsibility for the National Drugs Strategy) *Building on Experience: National Drugs Strategy, 2001 – 2008*, Dublin: Stationery Office.
- Sellman, D. (1994) "Alcoholism: development of the diagnostic concept", *Australian and New Zealand Journal of Psychiatry*, 28, 205-211.
- Sobell, M., Sobell, L. (1993) "Treatment for problem drinkers: a public health priority" in J. Baer, G. Marlatt, R. McMahon (eds.) *Addictive Behaviours Across the Life Span: Prevention, treatment and policy issues*, London: Sage.
- South Eastern Health Board (2001) *South Eastern Health Board Regional Treatment and Rehabilitation Working Group Recommendations*, Waterford: Author.
- Thom, B. (2001) "A social and political history of alcohol" in N. Heather, T. Peters, T. Stockwell (eds.) *International Handbook of Alcohol Dependence and Problems*, New York: Wiley.
- Weisner, C. (2002) "What is the scope of the problem and its impact on health and social systems" in W. Miller & C. Weisner, *Changing Substance Abuse Through Health & Social Systems*, London: Kluwer Academic / Plenum Publishers.
- WHO (World Health Organisation) (2000) *European Alcohol Action Plan, 2000-2005*, Geneva, WHO Regional Office for Europe

WHO (World Health Organisation) (1996) *Trends in Substance Use and Associated Health Problems*, Geneva, WHO

WHO (World Health Organization) (1967) (8th edition) *Manual of the International Classification of Diseases, Injuries and Causes of Death*, Geneva: Author.