



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

**Report of the HSE Working Group on Residential  
Treatment & Rehabilitation  
(Substance Abuse)**



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Treatment & Rehabilitation (Substance Users)**

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on behalf of the  
Working Group

May 2007

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# Foreword

In presenting this report from the HSE Working Group on Residential Treatment and Rehabilitation (Substance Users), I wish to pay tribute first of all to my colleagues on the working group for their thoughtful contributions and hard work during the preparation of this report. It is true to say that this report is their report because it embodies their knowledge, their expertise, their commitment and their experience of working in the area. The report is very much strengthened by their insights derived from working with individuals with alcohol and other drug-related problems.

The hard work and attention to detail displayed by members of the group at our meetings and between meetings has greatly facilitated the task of completing this report. For all of us involved it has been an invaluable learning experience, not least because we have been able to produce a comprehensive survey of existing inpatient and residential rehabilitation services for drug and alcohol users in Ireland. That achievement is due, in no small way, to all those in the statutory and voluntary drug and alcohol services and those responsible for the HIPE, NDTRS and NIPRS databases, who so readily shared information and willingly responded to further queries. To all those, the group offers its heartfelt thanks.

We are also enormously indebted to our technical advisor, Dr Aileen O’Gorman, and her assistant, Ms Marie Lowe, not only for their painstaking efforts to record and verify the existing level of service provision, but also for the excellence of their input to the overall work of the group. In particular, Aileen’s work in producing this final report is especially noteworthy and my admiration of her expertise and professionalism is shared by my colleagues on the group.

All of us owe much to Vinny Crossan of the HSE for his administrative and logistical support in ensuring that meeting rooms and minutes were always available and for keeping us refreshed. On a

personal note, I am grateful to Alice O’Flynn and her former colleague Cathal Morgan for inviting me to take on the task of chairing the group and for putting together such an excellent panel of members.

Our report charts a way forward for the inpatient/residential drug and alcohol services in this country in line with the strategic development of Rehabilitation as the Fifth Pillar of the National Drugs Strategy. We do not underestimate the various challenges involved in implementing the many recommendations we have made, but we hope that those involved in policy making and service development in the drugs and alcohol areas will, having studied our report and its conclusions, share our belief that provision of the resources required to deliver on what we recommend will result in significant benefits for everyone affected by problematic alcohol and/or other drug use in our society.



*Dr Des Corrigan  
Chairperson of the  
Working Group*

# Executive Summary

The National Drugs Strategy (NDS) 2001-2008 *Building on Experience* provides the policy framework for drug services in Ireland. The strategy, based initially on four pillars – supply reduction, education and prevention, treatment and research – identifies a series of 100 individual actions to be carried out by a number of Government departments and agencies. Through the NDS, the Health Service Executive (HSE) is mandated to provide a range of treatment and rehabilitation options, including residential components, to drug users experiencing problems.

In 2005, a mid-term review of the National Drugs Strategy recommended that rehabilitation be adopted as the fifth pillar of the strategy. Consequently, the issue of residential treatment capacity has arisen. - In 2006, the HSE appointed an expert working group to provide a detailed analysis and overview of known current residential treatment services and to advise on the future residential requirements of those affected by drug and alcohol use.

The working group commenced work with an in-depth mapping of existing inpatient detoxification and residential rehabilitation services in Ireland. Subsequently, different needs assessment models were examined and a population-based approach adopted to estimate the level of residential services required.

Arising from the detailed discussions within the group, analysis of submissions received by it, and a review of international literature and experience, the following have been agreed.

## Key Issues and Recommendations regarding the Role of Inpatient Detoxification and Residential Rehabilitation (Chapter 3)

- 3.1 The concept of the Four-Tier Model of Care as the framework for the future organisation of alcohol and drug services in Ireland is endorsed.
- 3.2 All four tiers of this model need to be fully resourced for the model to be fully effective because one tier cannot be developed or function in isolation from the others.
- 3.3 While not all problem alcohol or drug users will require Tier 4 (inpatient/residential) services, client outcomes are generally recognised as being superior for inpatient versus outpatient provision for those whose care plan calls for Tier 4 services.
- 3.4 The Four-Tier Model of Care implies that clients should be offered the least intensive intervention appropriate to their need when they present for treatment initially. Where this does not succeed, more intensive interventions should be offered.
- 3.5 The working group highlights the need for a standardised assessment protocol which allows for the systematic identification of the needs of the client ensuring that they are referred to the most appropriate treatment modality in the most appropriate setting.
- 3.6 The group recommends that where inpatient detoxification is required, it should be, as a rule, provided in dedicated units. The use of general hospital or psychiatric beds for detoxification should be the exception since the evidence base indicates better outcomes from specialist units.
- 3.7 Attention is drawn to the fact that detoxification itself is not an effective



treatment and that it must be followed up by post-detoxification psychosocial interventions as part of a client-centred rehabilitation programme.

- 3.8 The group emphasises that the transition from detoxification from alcohol or any other drug into rehabilitation should be seamless so as to avoid waiting lists and delays which can result in client relapse. It is recognised that in the case of relapse to opiate use, there is a major risk of fatal overdoses occurring at this time.

### Key Issues and Recommendations regarding Existing Service Provision (Chapter 4)

- 4.1 The working group calculated that currently in Ireland there are:
- 23 dedicated beds for medical detoxification and stabilisation;
  - 15 beds for community-based residential detoxification;
  - 634.5 residential rehabilitation beds, of which a significant proportion (31%) are for the treatment of alcohol problems only; and
  - 155 step-down/halfway house beds most of which (76%) are for men only.
- 4.2 The group estimates that currently the equivalent of 13 beds are used for detoxification in general hospital settings and the equivalent of 66 beds in psychiatric facilities; which is not in accordance with best practice.
- 4.3 The group recommends that clients with co-morbidity issues who are in residential drug and alcohol services should be provided with adequate support by the mental health services, and that clear pathways into residential mental health services for those requiring them should be agreed, as outlined in the NACD commissioned report on *Mental*

*Health and Addiction Services and the Management of Dual Diagnosis in Ireland* (MacGabhann et al., 2004)

- 4.4 The group further recommends that there should be flexibility across catchment areas to refer people with co-morbidity where an appropriate psychiatric service is not available in their own catchment area.
- 4.5 The group recommends that a similar National Working Group be established to estimate the current capacity of community-based services within Tiers 1, 2 and 3 as well as looking at the balance between all four tiers.
- 4.6 The working group recommends that GPs with Level 2 training be resourced to work within community-based residential programmes to provide residential detoxification.
- 4.7 The group also highlights the need to review community-based or outpatient detoxification services, including the role of Level 2 GPs in their provision.
- 4.8 The working group noted that prison provides an opportunity for both detoxification and rehabilitation and the group would welcome the extension of the existing programmes within Mountjoy prison as well as the establishment of similar programmes in all other prisons within the State. In this regard, there is a particular need to integrate alcohol treatment into overall programmes within Irish prisons.
- 4.9 The provision of step-down or halfway house accommodation for newly-released prisoners who have been detoxified or who have started rehabilitation programmes is particularly important, not least because of the vulnerability of such individuals to relapse and overdose.

4.10 A mechanism to track progression from treatment services to rehabilitation is required. This linkage can be achieved by use of a unique identifier which the group recommends be used for all contacts with drug services to enable integrated care planning in line with the rehabilitation strategy so that, with appropriate confidentiality procedures, cross referencing can be carried out.

4.11 The group recommends that a regularly updated directory of current residential services be made publicly available which would detail the programme approach and type of service provided.

4.12 In preparing the analysis and overview of current residential rehabilitation facilities, the group noted the need for an initiative which would examine in depth the configuration of existing services available, their programme approach, ethos and so on.

## **Key Issues and Recommendations relating to the Assessment of Need for Inpatient Detoxification, Stabilisation and Residential Rehabilitation (Chapter Five)**

5.1 There is a need for more refined data on drug and alcohol-related problems such as accidents at work, absenteeism and drug-related deaths, in order to allow the use of more sophisticated needs assessment models in future.

5.2 The working group based their estimation of need for inpatient detoxification and stabilisation services on the SCAN Consensus Project (a population-based model); the residential rehabilitation requirement was based on the transition from inpatient and outpatient detoxification to residential treatment; and the number of adolescents

requiring treatment was based on population surveys and estimates of problematic substance use.

5.3 The working group calculated that:

- Overall, 127 dedicated beds are required in Ireland for medical detoxification and stabilisation, 50% each for drug and alcohol detoxification.

- In total, 887 residential rehabilitation beds are required, of which between 14 and 37 beds are required for a separate adolescent service(s).

- These 887 residential rehabilitation beds will address the following needs: 205 for illicit drug users transferring from inpatient detoxification services; 382 for problem alcohol users transferring from inpatient detoxification services and 300 to address the needs of both drug or alcohol users who have attended outpatient detoxification services.

- A minimum of 30% of clients attending residential rehabilitation will require step-down/halfway house beds and therefore at least 296 step-down/halfway house beds are required.

5.3 The working group calculated that:

- an additional 104 inpatient unit beds (for medical detoxification and stabilisation);
- 252.5 residential rehabilitation beds; and
- 141 step-down/halfway house beds are required.

5.4 In highlighting a deficit of 356.5 beds (104 IPU and 252.5 rehabilitation) the working group notes the estimated 66 beds currently in use for alcohol and drug problems in the psychiatric hospitals and units will no longer be available as a result of the restructuring



proposed in *Vision for Change* and the necessity of ensuring that the current resource involved continues to be applied when remedying the deficit in dedicated beds.

- 5.5 The group recommends that 50 inpatient unit beds for illicit drug users should be provided between the Dublin Mid-Leinster and the Dublin North East HSE areas as the available data points to a significantly higher level of need there at present. The remaining 13 IPU beds should be divided between the HSE South and HSE West areas. The group draws attention to the fact that the results from the 2007 Capture-Recapture Study of Opiate Use currently being undertaken for the NACD may require a revision of this recommendation in the future.
- 5.6 In the case of services focusing primarily on the treatment of alcohol problems, the group recommends that the services be evenly spread over the four HSE areas since the data suggests a more even distribution of alcohol-related problems throughout the country.
- 5.7 The group's strong preference is that such beds should be provided in fully-staffed, dedicated units but recognise that problems of patient and family access may militate against this in some parts of the country.
- 5.8 The group recommends as a matter of urgency that, where there is unused capacity at present in a service or unit because of staffing shortages, such capacity be brought on stream immediately by providing the necessary staff.
- 5.9 The staffing of IPUs as well as of residential rehabilitation services must be in line with recognised best practice to ensure full occupancy, maximum client safety and the highest standards of care. Since the treatment approach adopted by a particular service will determine the staff mix required, it is neither possible nor desirable to be prescriptive about numbers or type of staff at this stage.
- 5.10 Arising from the group's recommendation that transitions from detoxification to residential rehabilitation and then into step-down accommodation be seamless (3.8), the group recommends that an appropriate residential rehabilitation place must be available for each person admitted for inpatient detoxification.
- 5.11 The group recommends that the treatment needs of problem drug and alcohol users who are homeless should be prioritised, since homelessness is one of the key criteria indicating client suitability for inpatient admission.
- 5.12 The increased provision of inpatient unit beds the group have recommended will allow for the stabilisation and respite needs of drug users including pregnant women, cocaine and/or polydrug users. Such stabilisation beds must be physically separated from detoxification beds.
- 5.13 The needs of recovering drug users with young children present particular challenges when it comes to inpatient/residential treatment. The group would welcome the investigation of innovative approaches such as providing the necessary supports so that family members can act as short-term foster parents.
- 5.14 In general, the group were of the opinion that families of drug and alcohol users could be more involved in the overall care plan for recovering users. In particular, the group draws attention to the recommendations in the NACD commissioned report *A Study into the Experiences of Families Seeking Support in Coping with Heroin Use* (Duggan, 2007) and to the specific recommendations on support for families and carers contained in the National Institute for Clinical Excellence's (NICE) guidelines.

5.15 The group agreed that the specific needs of substance users with disabilities and those from ethnic minority communities can be met within the increased facilities recommended, provided that staff training is used to enhance cultural competence within the service. Such training should form part of the proposed quality assurance framework for Tier 4 services outlined in Chapter Six.

5.16 The group recommends that the level of provision set out in this Report should be reviewed in March 2010 and that, in the meantime, the timeliness and completeness of the data required for more precise projections of need should be improved.

### **Key Issues and Recommendations regarding Quality Assurance of Inpatient and Residential Services for Alcohol and Drug Users (Chapter Six)**

6.1 The working group fully endorses the concept that the quality of the residential facilities, the organisation, the delivery and evaluation of services, and also of the staff involved in the delivery of the service must be of the highest possible standard. It is vital, therefore, that all three components be subject to regular auditing using recognised benchmarks and targets.

6.2 The group therefore recommends that a national quality assurance scheme for all four tiers of the alcohol and drugs services be established following the necessary consultation, negotiation and training.

6.3 We recommend that the *Quality in Alcohol and Drugs Services* (QuADS) suite of organisational standards and the companion *Drug and Alcohol National Occupational Standards* (DANOS), as developed for the UK by Alcohol Concern and Drugscope and by

the Management Standards Consultancy for Skills in Health respectively, should be adapted for use by drug and alcohol services in Ireland.

6.4 The group also recommends that there must be standards for the quality of the residential facilities themselves and believe that the HSE should enter into discussions with the Health Information and Quality Authority (HIQA) about the inclusion of residential services for drug and alcohol users within the range of services to be regulated by HIQA's social services inspectorate. This would help avoid duplication of effort when quality audits are undertaken.

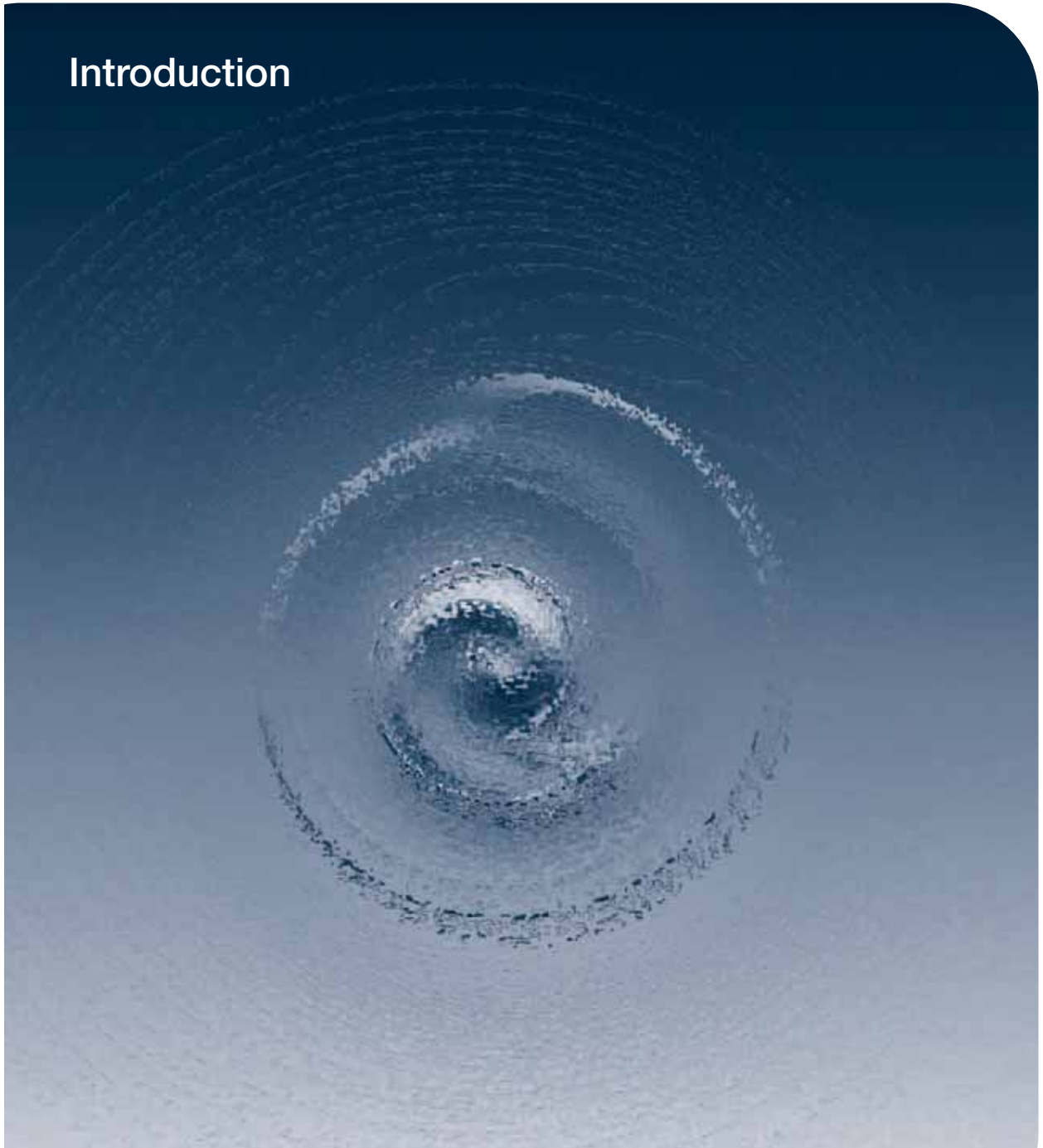
6.5 The group also recommends that the HSE put in place an Internal Quality Audit function within the drugs and alcohol services in order to assist both HSE-funded and HSE-provided services to prepare for and respond to external audits of the facilities, organisation and staff.

6.6 There was particular concern expressed by the group about the need for relevant stakeholders to ensure that all detoxification procedures meet the highest standards of clinical governance, care and patient safety.

6.7 The group highlights the need for ongoing staff training and support to assist in role development. Managers and those who lead rehabilitation teams should ensure that staff are clear about their role definition and purpose, and that they possess or are actively working towards the required qualification(s).

# Chapter 1

## Introduction



## Background and Strategic Context

The National Drugs Strategy (NDS) 2001-2008 *Building on Experience* provides the policy framework for drug services in Ireland. The strategy based initially on four pillars – supply reduction, education and prevention, treatment and research – identifies a series of 100 individual actions to be carried out by a number of Government departments and agencies. Through the NDS, the Health Service Executive (HSE) is mandated to provide a range of treatment and rehabilitation options, including residential components, to drug users experiencing problems.

In 2005, a mid-term review of the National Drugs Strategy recommended that rehabilitation be adopted as the fifth pillar of the strategy and that a working group be set up to develop an integrated rehabilitation provision. This working group on rehabilitation has consistently acknowledged the need for additional rehabilitation/treatment residential capacity. As a result, the Health Service Executive proposed that a working group be established in order to advise the HSE in relation to the future residential treatment requirements (in terms of range, scope, need and quality) of those affected by drug and alcohol use.

## Terms of Reference of the Working Group

The scope and parameters of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Users) were set out in the Terms of Reference (ToR) as follows:

- a. To provide the HSE with a detailed analysis and overview of known current residential treatment facilities offered to those affected by problem drug and alcohol use in Ireland. For the purposes of this expert working group, residential treatment/rehabilitation incorporates the following modalities known to be on offer:
  - i. Stabilisation Units
  - ii. Community-Based Residential Detoxification Units
  - iii. Medical Detoxification Units

- iv. Residential Rehabilitation Units
- v. Step Down or Halfway Accommodation

- b. To provide the HSE with an expert view as to the future range, scope, type and method of delivery (e.g. tiered service provision as provided for in the National Treatment Protocol for Under 18s in the UK) of residential treatment required going forward. In particular, the working group should advise on the following basis:

- What is the optimum type, range and scope of residential treatment services which should be on offer based on current available prevalence studies (as provided via the Central Treatment List, HRB Drug Misuse Research Division [now the Alcohol and Drug Research Unit], and the National Advisory Committee on Drugs). That is, per head of population, we should have 'x' beds available delivered using 'x' model in 'x' setting'.
- What is the current range and type available in both the statutory and NGO sector in respect of the above. The group is asked to map and verify current residential treatment services known to be available.
- Advise on the appropriate geographical location and setting for all residential treatment units (i.e. whether there should regional, national and local services).

- c. To examine current international quality/standards frameworks existing for residential treatment providers operational in other jurisdictions and advise the HSE in terms of what overall standards/quality framework are required for implementation throughout all HSE-funded residential treatment facilities.

- d. To take into account and be fully cognisant of the report and recommendations arising from the working group on establishing rehabilitation as the fifth pillar of the National Drug Strategy once produced.

The working group is required to forward a set of recommendations via the Chair as in keeping with the ToR. Whilst the HSE will endeavour to implement the recommendations of the working group subject to available resources, it is not bound in absolute terms to the recommendations arising from the working group's deliberations and recommendations.

### Time Frame and Process

In July 2006, the HSE appointed an independent Chair, whose role was:

- to ensure that the group met the terms of reference as set out above in parts a), b), c) and d);
- to ensure that all requested reports were furnished to the HSE within the agreed parameters and timelines;
- to ensure that a work programme was agreed with the working group in order to fulfil the ToR;
- to act as a liaison (with field worker assistance) on behalf of the working group with all external stakeholders.

In early August 2006, the HSE issued a letter of invitation to individuals and organisations representing all facets of the response to problematic substance misuse to become a member of the working group. The multidisciplinary working group thus included those with expertise in the field of addiction, particularly in residential treatment/rehabilitation; policy/strategic and operational management, and the service user perspective - (see list of members in Appendix 1). Later that month, a technical advisor to the working group was appointed by the HSE.

The inaugural meeting of the working group was held on 6 September 2006 and seven further

meetings were held. In mid October, a formal, written *Progress Report* was submitted to the HSE by the Chair of the working group. At the group's final meeting on 7 March 2007, the text of a final report with recommendations was agreed and subsequently submitted by the Chair to the National Group Care Manager, Social Inclusion, HSE.

At its first meeting, the working group noted and accepted the ToR as presented to it with one amendment – namely that ToR (c) should now read “To examine current international quality/standards frameworks existing for residential treatment providers operational in other jurisdictions and advise the HSE in terms of what overall standards/quality framework are required for implementation throughout all HSE-funded residential treatment *facilities and act as a benchmark for all services* (amendment in italics).

Subsequent meetings examined in turn each aspect of the work laid out in the ToR such as: reviewing the literature on inpatient treatment; collating and verifying current residential service provision; examining needs assessment models for drug and alcohol services; calculating the extent and range of future residential service provision for substance users in Ireland; and assessing an appropriate quality framework for such services. In addition, a number of written submissions were made to the working group which informed discussions (see Appendix 2). In addition, the working group noted the recently published joint report from the NACD/NDST *An Overview of Cocaine Use in Ireland* // and, in particular, the impact of cocaine use on the delivery of treatment services and also the work of the Department of Health and Children examining synergies between the national drug and alcohol strategies.

In preparing the analysis and overview of known current residential treatment facilities offered to those affected by problem drug and alcohol use in Ireland, the group proceeded on the assumption that the configuration of types of residential rehabilitation available actually meets the differing needs of diverse client populations. It was recognised that,

while it was not possible to examine the configuration of existing services during this present exercise, there is a need for such an initiative, taking into account international best practice, differing client profiles and changes in drug-using behaviour.

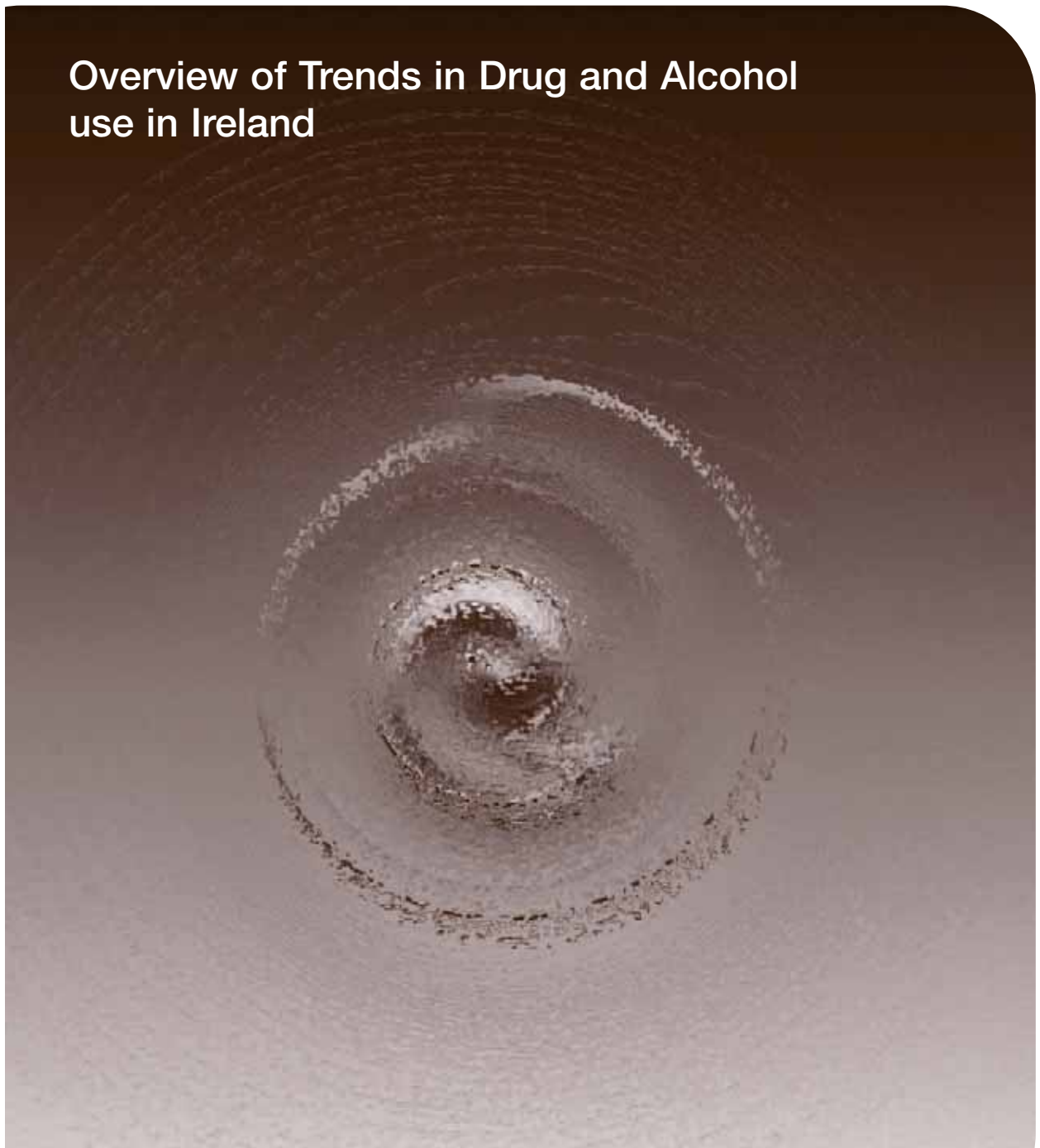
## **Outline of the Report**

Chapter Two presents an assessment of trends and patterns in drug and alcohol use in Ireland. This is followed by a review of the findings of relevant literature regarding the role of inpatient treatment in substance misuse in Chapter Three. Chapter Four assesses existing service provision for residential treatment and sets out what is known to date about existing residential drug and alcohol services in terms of service type, programme details, capacity etc. (Further details are presented in Appendix 3). Chapter Five examines international needs assessment models for calculating the number and range of residential drug and alcohol services, and applies the most appropriate model to available Irish data. The report concludes with an assessment of quality assurance frameworks.



## Chapter 2

Overview of Trends in Drug and Alcohol  
use in Ireland



## Background

This chapter presents an overview of trends in the prevalence and patterns of alcohol and drug use in Ireland. In recent years, considerable advances have been made in our evidence-based knowledge of drug and alcohol use. Nonetheless, significant information gaps remain, particularly with regard to local patterns of use and current patterns of use. Notwithstanding that much of the available data is now a number of years old, the group's analysis of alcohol and drug trends in Ireland indicates a high level of risk behaviour in relation to alcohol and drug use.

## Overall alcohol trends

Findings from the drug prevalence household survey 2002/3 (NACD/DAIRU, 2005<sup>1</sup>) report a lifetime alcohol prevalence rate of 90% for adults aged 15-64 in Ireland, with rates for recent (last year) and current (last month) use at 84% and 74% respectively. Similar rates of current use were reported by younger (15-34) and older (35-64) adults, though males (78%) reported higher current rates than females (70%). Overall, higher rates of alcohol consumption were reported in urban areas, particularly on the eastern seaboard. (NACD/DAIRU 2002; SLAN 2002).

The SLAN 2002 Health and Lifestyle Survey reported that almost a quarter (23%) of respondents were regular weekly drinkers and over the recommended weekly limit for alcohol consumption. The survey also noted that though traditionally more men than women were regular drinkers, the ratio of male to female drinkers is now much less marked, particularly in urban areas and among the younger age groups (Kelleher et al. 2003).

## Alcohol use among young people

Although there are some indications that the prevalence of alcohol use has decreased among younger people, levels of use remain a concern. The Health Behaviour in School-Aged Children (HBSC) survey (2002) reported that among the 12-14 age

group, 16% of boys and 12% of girls were current drinkers. And, in the 15-17 age group, about half of the boys and girls were regular drinkers and drunkenness was also prevalent (60% boys, 56% girls), (Kelleher et al. 2003).

## Trends in alcohol use in Ireland in a European context

The Department of Health and Children (2002) define high-risk drinking as the type of drinking that is likely to increase the risk of harm for the drinker or for others, such as binge drinking<sup>2</sup>, drinking to intoxication and regular heavy drinking. They note that binge drinking and drinking to intoxication is particularly linked to an increased risk of short-term (acute) harm such as accidents, injuries, violence and poisoning; and that drinking above the guidelines of more than 14 standard drinks per week for women and 21 for men is linked to increased risk of long-term (chronic) harm, such as high blood pressure, cancers, cirrhosis and alcohol abuse.

Notwithstanding difficulties in comparing drug and alcohol statistics across countries, the available evidence indicates that the level of high-risk drinking in Ireland has increased in recent years and is substantially higher compared to other European countries.

Ireland's per capita litre consumption of alcohol<sup>3</sup> has almost doubled from 7.0L in 1970 to 13.5L in 2003 – the third highest level after Luxembourg and France (OECD, 2006).

Similar evidence from Eurostat (2002) indicates that Irish people are twice as likely to be regular drinkers of alcohol compared with the European average. One in two (51%) Irish people are regular drinkers of alcohol compared to the EU average of one in four (25%). Over half (53%) of Irish men are regular drinkers, compared with the EU average of a third (33%). This figure increases to 80% for men in the 25 to 34 age group, compared with an EU average of 36%. And, half (50%) of Irish women aged 15 to

<sup>1</sup> A repeat of this survey for 2006/7 is currently underway.

<sup>2</sup> Binge drinking - defined by the World Health Organisation (WHO) as six or more standard drinks (60 grams of pure alcohol).

<sup>3</sup> Population aged 15+

24 are regular drinkers, compared with the EU average of 19%.

The European Comparative Alcohol Study (ECAS) study showed that though Irish respondents<sup>4</sup> had the lowest rates of everyday drinking, they had the highest rates of binge drinking<sup>5</sup>. Binge drinking was seen to be the norm among Irish men; out of every 100 drinking occasions, 58 result in binge drinking. Among women, 30 occasions out of 100 result in binge drinking. In addition, young Irish men (18-29 age group) reported the highest consumption of alcohol and had more binge drinkers than any other group in the population. (Ramstedt and Hope, 2002)

A similar trend of high-risk drinking is evident among younger Irish people in comparison to their European counterparts. In 2003, the European School Survey Project on Alcohol and Other Drugs (ESPAD) found that the proportion of Irish students who had drunk any alcohol during the last 12 months to be a little higher than the ESPAD average (88% compared to 83%). However, the proportion of Irish respondents reporting having been drunk during the last 12 months (72%); being drunk three or more times in the last 30 days (26%); and binge drinking three times or more in the last 30 days (32%) was substantially higher than the ESPAD average<sup>6</sup>.

### Impact of alcohol use

The impact of high-risk drinking is seen to contribute to a variety of physical and mental health problems in Ireland. Standardised mortality rates for liver cirrhosis doubled among Irish men from 5.4 per 100,000 per year between 1957 and 1961 to 11.1 per 100,000 between 1997 and 2001. The corresponding figures for Irish women were 3.9 and 6.5 respectively. In comparative terms, the mortality rate in Ireland was the third highest of 14 European countries analysed; the rate in women in the 45-64 age group was the joint highest with Scotland. (Leon & McCambridge, 2006)

Results from the 2003 SLAN Health and Lifestyle Survey found that the top three problems resulting from one's own drinking were identified as: being drunk (35%); feeling they should cut down their level of alcohol use (14%); and feeling the effects of alcohol while at work (14%). The top three problems resulting from someone else's drinking were identified as: having arguments with family and friends about drinking (6%); being verbally abused (6%); having family/marital difficulties (3%). (Kelleher *et al*: 31)

In addition, the Health Promotion Policy Unit has identified a number of alcohol-related harms which they note as having increased in line with the increased rate of alcohol consumption in recent years. These include:

- Alcohol intake is a factor in 40% of all fatal road accidents in Ireland and in 30% of all road accidents.
- Almost half (48%) of all criminal offences committed by adults are alcohol related. This includes 88% of public order offences, 48% of offences against the person and 54% of all criminal damage offences.
- A 370% increase in intoxication in public places by underage drinkers since 1996.
- A third (34%) of those seeking legal advice due to marital breakdown cite alcohol as the main cause of their marital problems.
- Over a third (35%) of sexually active teenagers say alcohol is a factor in their engaging in sex – overall, sexually transmitted infections have increased by 165% in the last decade.
- In 1999, the economic cost of alcohol-related problems in Ireland was roughly €2.37 billion (1.7% of GDP). This figure encompassed healthcare costs, accidents, crime, absenteeism, transfer payments and lost taxes. It represents 60% of the total revenue from alcohol to the Exchequer for that year.

<sup>4</sup> Respondents aged 18-64 years.

<sup>5</sup> Defined in this study as drinking at least one bottle of wine, or 7 measures of spirits, or 4 pints of beer or more, during one drinking occasion (75/80 grams of pure alcohol).

<sup>6</sup> Defined by ESPAD as having 5 drinks or more in a row.

## Impact of alcohol use on health services

In 2005/6, the ICGP Alcohol Aware Practice Initiative randomly screened 4,584 patients in surgeries. Results showed that 61% of these patients were in the low/no risk category, while 22% were in the “hazardous” zone and 17% were “harmful/dependent”. Many of these patients would benefit from community-based alcohol services if more were available.

Recent data from the Hospital Inpatient Enquiry (HIPE) database<sup>7</sup> show that almost 11,500 episodes of care provided in Irish public hospitals in 2005 had a discharge diagnosis relating to alcohol – this accounts for 1.14% of all episodes reported to HIPE. Almost three-quarters of these episodes of care were to male patients (n=8447). The HPU (2002) have noted that 30% of all male patients and 8% of female patients in an Irish general hospital were found to have an underlying and unidentified alcohol abuse or dependency problem.

Data from the National Psychiatric Inpatient Reporting System’s (NPIRS) database showed that of the 22,279 admissions to psychiatric units and hospitals in 2004, 3,217 (14% of all admissions) were for alcohol disorders (ICD-10 Code F10) – the third highest after depressive disorders and schizophrenia. Admission rates for alcoholic disorders were 106.2 per 100,000 population aged 16 years and over, with the male rate of admissions (149.7) more than twice that of the female rate (64.1).

A pilot study on the role of alcohol in Accident and Emergency Room attendance carried out in 2001 showed that alcohol was a contributory factor for one in four patients attending the A&E department (HPU, 2002). Hope *et al* (2005) examined the association between injury and alcohol use among persons attending A&E departments in 2003/4. Of the 2,085 patients who participated in the study,

almost a quarter (23%, n=478) had an alcohol-related injury. Over three-quarters (77%) of the participants were clinically assessed as moderately or severely intoxicated.

## Trends in drug use

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines problem drug use as injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines. Most drug treatment in Ireland is targeted at this level of use. In addition, polydrug use (in particular cocaine and alcohol) and dual diagnosis have been identified as significant concerns to the HSE both in terms of service development requirements and in relation to treatment responses<sup>8</sup>.

The 2002/3 Drug Prevalence Survey (NACD/DAIRU, 2004) found almost one in five (19%) respondents reported ever taking an illegal drug, of which cannabis was the most commonly used drug. However, household prevalence surveys do not tend to capture more problematic levels of drug use and, as expected, the prevalence rates reported for heroin, cocaine and amphetamine use were low although higher rates were reported in the eastern urban regions and among the younger age groups.

Using capture-recapture methodology to identify more hidden and problematic levels of drug use<sup>9</sup>, Kelly *et al* (2004) estimated that in 2001 there were 14,452 opiate users in Ireland – 12,456 in Dublin and 2,225 in the rest of Ireland. The overall rate per 1,000 population aged 15–64 years was 5.6, with higher rates for men than women in all age groups. The study indicated that opiate use was still predominately a Dublin phenomenon with a rate of 15.9 per 1,000 population aged 15–64 years in Dublin compared with a rate of just under 1.2 per 1,000 population aged 15–64 years outside Dublin.

Most recent data from the Central Treatment List (of all individuals receiving methadone treatment for an opiate problem) show 8,291 people attending for

<sup>7</sup> HIPE records the primary and secondary diagnoses of all patients discharged from Irish Public Hospitals (private hospitals are not included). Each HIPE discharge record represents one episode of care and patients may have been admitted to hospital(s) more than once with the same or different diagnoses. The records therefore facilitate analyses of hospital activity rather than incidence or prevalence of disease.

<sup>8</sup> HSE Terms of Reference Residential Expert Working Group

<sup>9</sup> Capture Recapture Methodology used three national data sources for the years 2000 and 2001 - clients in methadone substitution treatment, individuals known to be opiate users by An Garda Síochána, and patients discharged from hospitals with an ICD code relating to drug dependence.

treatment in February 2007, over two-thirds (69%) of whom are male. The vast majority of people were attending clinics and GPs in the Dublin area. However, an increasing number of people are being treated in clinics and by GPs outside of the (former) Eastern Regional Health Authority area.

Data from the National Drug Treatment Reporting System (NDTRS) indicates a continued growth in the level of demand for drug treatment services<sup>10</sup> and in the number of drug treatment services. The NDTRS data indicates that though a substantially higher proportion of numbers treated for problem drug use are living in the HSE Eastern Region than the rest of the country (71% compared to 29%), the proportion of numbers treated of those living outside the HSE Eastern Region has almost doubled from 1998 (15%) to 2003 (29%), (Long *et al* 2005).

According to data from the General Mortality Register, in 2003 there were almost 100 drug-related deaths<sup>11</sup> (n=96) – a marginal increase when compared to 2001 (n=93) and 2002 (n=90). Between 2001 and 2003, 60% of direct drug-related deaths were opiate related. Between 2000 and 2003, there was a sharp decline in direct drug-related deaths in Dublin, from 83 in 2000 to 46 in 2003. During this period there was a continued increase in drug-related deaths outside Dublin, from 30 in 2000 to 50 in 2003. In 2003, the number of drug-related deaths outside Dublin exceeded the number of drug-related deaths in Dublin for the first time (DMRD, HRB, 2006).

Since 2000 there has been a steady increase in heroin-related prosecutions in the Eastern Region (Carlow/Kildare, Laois/Offaly, Longford/Westmeath, Louth/Meath), from 24 prosecutions in 2000 to 128 in 2005, and to a lesser extent in the South Eastern region (Tipperary, Waterford/Kilkenny, Wexford/Wicklow) – further evidence that, although heroin use remains predominantly a Dublin-based phenomenon, it is no longer confined exclusively to the capital (DMRD/HRB, 2006:81-82).

## Cocaine Use

The 2002/3 Drug Prevalence Survey (NACD/DAIRU 2005) found that lifetime cocaine use was much higher in the three former health board areas around Dublin than in other areas (former East Coast Area Health Board (6%), former Northern Area Health Board (5%) and former South Western Area Health Board (5%) confirming anecdotal evidence that cocaine use is primarily an urban problem. Data from this survey also suggests the extent of normalisation of cocaine use among recent users – one third (33%) had been given the drug by family or friends; almost one fifth (19%) had shared the drug amongst friends; one quarter (25%) had bought the drug from a friend; and over half (52%) said they had obtained cocaine at the house of a friend. The majority of recent users (68%) considered it “very easy” or “fairly easy” to obtain cocaine within a 24-hour period.

NDTRS data also indicates a growth in the level of treatment demand for problem cocaine use. During 2004, almost one third of cases (31%, n=352), reported cocaine as a problem drug. Of those who reported cocaine as their main problem drug, over half (58%) had entered treatment for the first time; 20% were female; and almost half (49%) were aged between 20 and 24 years, while 16% were aged between 15 and 19 years. Eighty six per cent used more than one drug; the most common additional drugs were cannabis, alcohol, stimulants and opiates. One in seven of the treated cases reported injecting cocaine (DMRD/HRB, 2006:98).

In 2005, the number of cocaine-related offences under the Misuse of Drugs Act (n=1,224) was greater than heroin-related offences (n=1,022). Cocaine-related offences accounted for 13% of all offences – the most common drug cited after cannabis and cannabis resin (An Garda Síochána, 2006).

The increase in cocaine use and its impact on service delivery has been further noted in the recent

<sup>10</sup> Treatment is defined here as “any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems.”

<sup>11</sup> The National Drug-Related Deaths Index was launched in 2005. The index will provide an accurate mechanism for recording Drug-Related Deaths compiling data from a number of sources including the coroner service, Hospital Inpatient Enquiry Scheme, Central Treatment List and General Mortality Register.



(March 2007) NACD/NDST report *An Overview of Cocaine Use in Ireland II*. This report also noted that cocaine consumption is more likely among men and among people in the 15-34 age bracket, and in the east, south and south east of the country.

### **Drug use among young people and other vulnerable groups**

Smyth and O'Brien's (2004:68) profile of children presenting to addiction treatment services in Dublin during the 1990s found there was a sharp increase in the number of children seeking treatment after 1993, with almost half (48%) of the cases relating to opiates. As the decade progressed, the proportion of girls increased. Injecting was reported more frequently and there was a dramatic rise in heroin misuse. Child heroin users were more likely to be female and to be homeless compared to their adult counterparts.

The Youth Homelessness Strategy, which focuses on young people and children under the age of 18, reports that 98 (17%) of the 588 children who presented to the health boards in 2000 as homeless, attributed their homelessness to their parents' or their own abuse of alcohol and/or drugs. The strategy notes that homeless young people who were not yet involved in drug misuse were particularly at risk of becoming involved in such misuse because of their own vulnerability and lack of resources (DMRD/HRB, 2006:90).

### **Drug Use and Homelessness**

Data from a number of prevalence studies have indicated higher levels of drug and alcohol use among more vulnerable groups. Almost one third (30%) of the homeless population had used heroin in the past year (compared to 0.1% of the general population) and over a quarter (28%) of homeless people had used cocaine within the past year (compared to 1% in the general population). Alcohol, however, was the substance most used with almost three-quarters (73%) being classified as problematic alcohol users. Many were polydrug users, were likely to be dependent on drugs (30% in Dublin) and were using drugs in riskier ways (such as injecting and

sharing injecting paraphernalia). Many were Hepatitis C positive and many had concerns about their psychiatric health though only 42% had ever had a psychiatric assessment (Lawless and Corr, 2005).

### **Dual Diagnosis**

Seven hundred and twenty four (of 22,279) admissions to psychiatric units and hospitals in 2004 were for other drug disorders<sup>12</sup> (Daly et al, 2005). This figure may underestimate the level of dual diagnosis as many of those with co-existing drug and mental health problems find it difficult to access treatment services (MacGabhann *et al.*, 2004).

Internationally the prevalence of dual diagnosis is estimated to lie between 15-60% of substance misusing clients (EMCDDA Annual report 2004). The limited Irish data ranges from 26% reported by the National Inpatient Psychiatric Reporting System (EMCDDA, 2004) to 43% in a community sample (Condren *et al* 2001). Kamali et al (2000) reported 37% of inpatients meeting criteria for dual diagnosis. More recently, Whitty and O'Connor (2006) reported that 37% of a group of patients attending the Drug Treatment Centre Board had a dual diagnosis. Major depression was diagnosed in 26% and 11% had psychoses.

Because those with co-morbid substance dependence and psychiatric problems are seen as a major target group particularly in need of inpatient interventions, the level of such dual diagnosis is important in assessing treatment needs.

### **Summary and conclusion**

Overall, the available evidence indicates high levels of risk behaviour in relation to the consumption of alcohol and drugs, particularly in urban areas, among young people and vulnerable groups and increasingly among women. The implications of this level of use for treatment services and, in particular, for inpatient treatment is discussed in Chapter Three.

<sup>12</sup> ICD-10 Code F11-19, F55



Furthermore, the reliance on dated and patchy data to conduct an analysis of current alcohol and drug trends has implications for the working group in terms of adapting international models of treatment need assessment (particularly inpatient treatment need assessment) to the Irish context, as is discussed in Chapter Five.

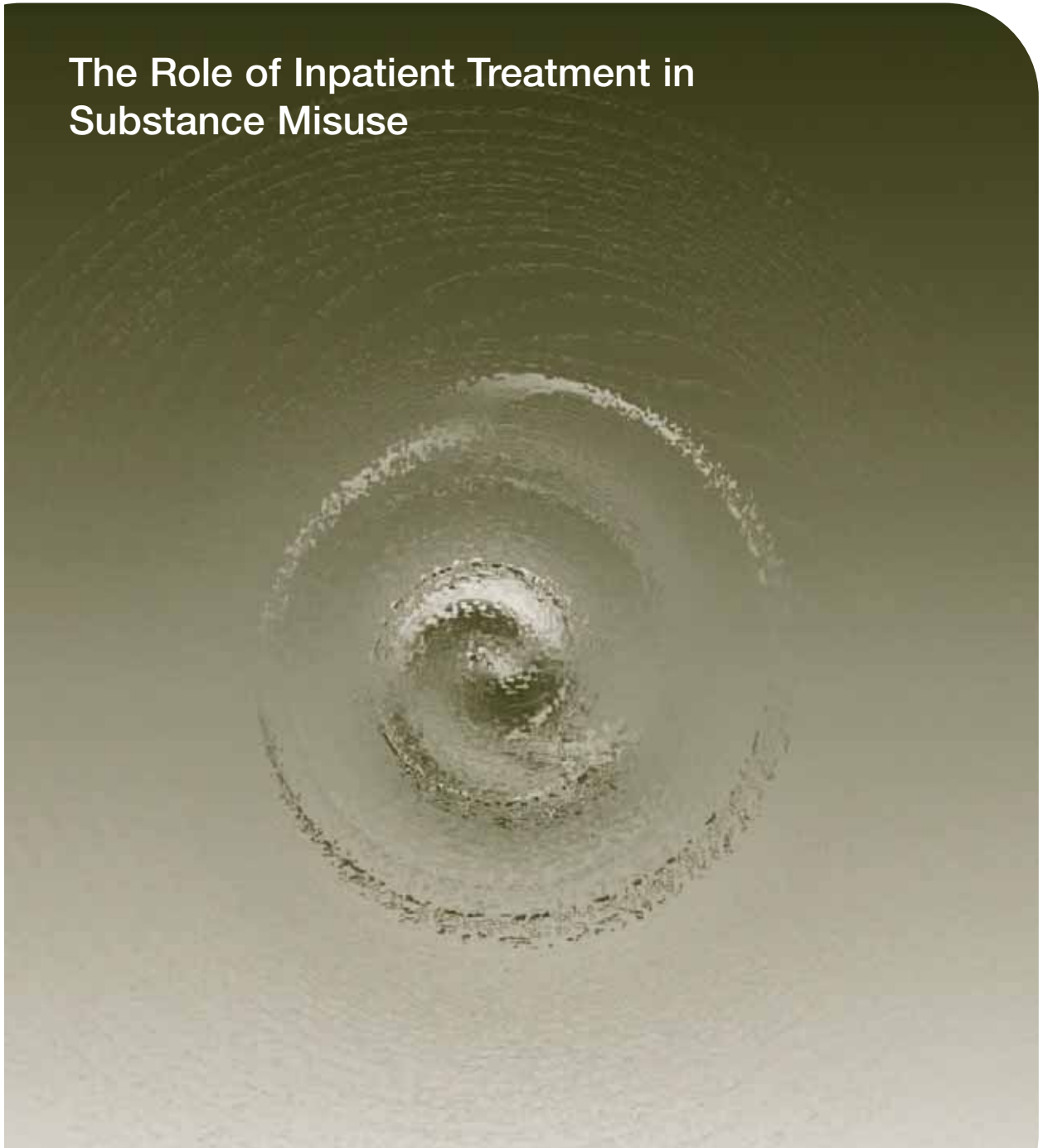
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## Chapter 3

### The Role of Inpatient Treatment in Substance Misuse



The use of a variety of psychoactive substances (alcohol, medicines and illicit drugs) results in a considerable public health burden in European countries (Rehm *et al* 2005 (a) & (b)). The World Health Organisation's Comparative Risk Analysis referred to by Rehm *et al* estimated that 2.1% of the burden of disease in Europe was attributable to the use of illicit drugs such as opioids, cocaine and amphetamines. This is in addition to the 10.2% of all disease burden due to alcohol. The point has been made that the public health impact of illicit drug use is underestimated if it is judged solely on the basis of burden of disease and also, that estimates of the prevalence of problematic illicit drug use are too low.

A variety of treatment responses and interventions have been made available to individuals with Alcohol Use Disorder (AUD), Drug Use Disorder (DUD) or both. This is because of the health and social consequences of AUD, i.e. alcohol dependence and abuse (Diagnostic and Statistical Manual of Mental Disorders - IV) or harmful use (International Classification of Diseases -10), and of DUD, i.e. drug dependence and harmful use (International Classification of Diseases -10; Diagnostic and Statistical Manual of Mental Disorders - IV). Studies of the effectiveness of treatment are consistent in reporting reduced substance use, improvements in personal health and social functioning and reduced public health and safety risks (McLellan *et al* 1997, ROSIE 2006). These gains have been shown in clients with different types of problems, using different interventions and in different treatment settings (Gossop 2006).

A diverse range of interventions (described by Gossop as specific change techniques) is available for those with AUD or DUD. Some involve pharmacotherapy e.g. methadone maintenance, or prescription of Antabuse®; some involve psychosocial treatments such as motivational interviewing and relapse prevention; while others involve harm reduction programmes. Many interventions build on abstinence from alcohol and other drug use e.g. Alcoholics Anonymous, Narcotics Anonymous and the Therapeutic Community

approach. These interventions are dependent on clients becoming abstinent through some form of detoxification process. It has been known for over 20 years that detoxification itself is not a treatment for either alcohol or drug dependence as it is not effective on its own in producing long-term abstinence. Detoxification can be provided in both residential and outpatient settings using either pharmacotherapy to alleviate the acute withdrawal symptoms or non-pharmacological interventions or a combination of both.

It is well recognised that no single treatment is universally effective for drug dependency. A range of different interventions is required which can meet the needs of diverse clients at different stages of their drug-using careers. In practice, treatment programmes provide a package of different interventions and services to clients who have, in all probability, received several treatment episodes. Because addiction is now seen as a chronic, relapsing disorder, the ultimate goal of long-term abstinence often requires sustained and repeated treatment episodes.

In both the UK and USA there is agreement that treatment should be tailored to the individual, guided by an individualised treatment plan and based on a choice of treatment levels where the preferred level of care is the least intensive one which meets the treatment objectives while ensuring the safety and security of the patient (Mee-Lee *et al* 2003).

In the UK this concept has been enshrined in *Models of Care for the Treatment of Adult Drug Misusers* published by the National Treatment Agency for Substance Misuse in 2002 and updated in 2006. In this conceptual framework, services for substance users were grouped into four broad tiers. Inpatient drug or alcohol misuse treatment was designated as a *Tier 4(a)* service within *Models of Care*, alongside residential rehabilitation services, whereas highly specialised, non-substance-misuse-specific services such as liver units and forensic services for mentally ill offenders were labelled as *Tier 4 (b)*.

In the Irish context, this tiered model of treatment was recommended as the basis for service delivery to child and adolescent problem drug users by the *Working Group on Treatment of under 18-year-olds presenting to Treatment Services with Serious Drug Problems* (DOHC & HSE 2005).

The concept of tiered service provision was specifically referred to in the Terms of Reference for this working group. Arising from this, the working group considered the concept as set out in the UK documentation and agreed that its views on the provision of inpatient detoxification and residential rehabilitation services would be framed in the context of a Four-Tier level of Care concept. This assumes, however, that such a four-tier Model has been brought into existence in Ireland; that it is fully functioning and that most important of all that all tiers are fully resourced.

### The Four-Tier Model of Care

In this model, *Tier 1* interventions include the provision of drug-related information and advice, screening and referral to specialised drug treatment services. They are delivered in general healthcare settings (A&E, liver units, antenatal clinics, pharmacies, or in social care, education or criminal justice settings [probation, courts, prison]).

*Tier 2* interventions are delivered through outreach, primary care, pharmacies, and criminal justice settings as well as by specialist drug treatment services, which are community- or hospital-based. The interventions include information and advice, triage, referral to structured drug treatment, brief interventions and harm reduction e.g. needle exchange programmes.

*Tier 3* interventions are mainly delivered in specialised structured community addiction services as indicated above, but can also be sited in primary care settings such as Level 1 or Level 2 GPs, pharmacies, prisons, and the probation service. Typically, the interventions consist of community-based specialised drug assessment and co-ordinated, care-planned treatment which includes psychotherapeutic interventions, methadone maintenance, detoxification and day care.

### Tier 4 Services

*Tier 4* is of direct interest in the context of this report and includes residential specialised drug treatment, which involves care planning and coordination to ensure continuity of care and aftercare. The care is provided by specialised and dedicated inpatient or residential units or wards, which provide inpatient detoxification (IPD) or assisted withdrawal and/or stabilisation. Some patients will require inpatient treatment in general psychiatric wards. Acute hospital provision with specialist “addiction” support will be needed for those with complex needs e.g. pregnancy, liver and HIV-related problems. Others will need IPD linked to residential rehabilitation units to ensure seamless care. “Step-down” or halfway house accommodation may be required to be made available away from the individual’s area of residence and drug-using networks.

In the alcohol treatment field, the Department of Health in the UK has recently published *Models of Care for Alcohol Misusers (MoCAM)* which it states is informed by the 2002 drug misuse document (now abbreviated to *MoCDM* and updated to 2006). In the case of alcohol, *Tier 1* consists of a range of interventions that can be provided by generic providers including those designated *Tier 4(b)* in *MoCDM* e.g. care delivered by inpatient liver units. In the new alcohol model i.e. *MoCAM*, *Tier 4* interventions include provision of residential, specialised, alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare. These are set in specialised statutory, independent or voluntary sector inpatient facilities for detoxification, stabilisation and assessment, as well as residential rehabilitation units. *MoCAM* states:

*dedicated specialist, inpatient alcohol units are ideal for inpatient alcohol assessment, medically assisted alcohol withdrawal (detoxification) and stabilisation. Inpatient provision, in the context of general psychiatric wards, may only be ideal for some patients with co-morbid, severe mental illness, but many such patients might benefit from a dedicated addiction-specialist inpatient unit.*



A significant driver for both MoCDM and MoCAM is an increase in the effectiveness of treatment partly ensuring that treatment is evidence-based and underpinned by good audit or clinical governance mechanisms.

## **The effectiveness of inpatient treatment approaches**

There is ample evidence from national (ROSIE 2006) and international treatment outcome studies (NTORS, DATOS and ATOS) that substance misuse treatments can be effective, and the belief is that the research question should no longer be whether treatment is effective, but rather how it can be tailored to the needs of different clients. While studies of treatment outcomes in general are commonplace, studies of inpatient services are relatively rare. In a 1996 article entitled "Are detoxification programmes effective?" in *The Lancet*, Mattick and Hall dealt in detail with the impact of the setting on alcohol and opioid detoxification. In relation to alcohol, they noted the following (page 98):

### **Setting for, and types of, alcohol detoxification**

*Until a decade or so ago, standard alcohol detoxification was inpatient, fully medicalised treatment in a specialist drug and alcohol unit, usually with pharmacological management of withdrawal symptoms by decreasing doses of sedative drugs such as chlormethiazole or diazepam. The major change in the past decade has followed the realisation that a broader range of detoxification approaches can deal with the wide range of withdrawal symptoms. Although residential specialist detoxification continues to have a role, it need no longer be the method of first choice, although it unfortunately still remains so in many places.*

*Many people with mild-to-moderate withdrawal symptoms can be detoxified safely, successfully, and much more cheaply at home under the supervision of a visiting nurse to administer anxiolytic drugs, with*

*medical practitioners providing necessary medical support. Even severely dependent drinkers may be detoxified safely and effectively at home with a minimum medication and the support of a visiting nurse. Rates of completion for outpatient detoxification are sometimes, but not always, lower than residential detoxification programmes, probably because of greater availability of alcohol. Outpatient detoxification, however, is more acceptable to a wider range of dependent drinkers, many of whom are reluctant to be treated in a designated detoxification unit because of the attendant stigma. Even when patients do not complete ambulatory detoxification, there is little evidence of serious medical or psychiatric complications.*

*Residential treatment seems necessary for the small proportion of dependent drinkers who are at risk of experiencing severe withdrawal symptoms (e.g. those with a history of such symptoms, or a recent history of very high alcohol intake) and those who do not live in an environment that supports outpatient detoxification (e.g. the homeless, or those living in boarding houses where there are other heavy drinkers). Residential detoxification need not, however, be pharmacologically assisted or medically supervised. Clinical experience in "non-medical" detoxification units in Canada and Australia shows that in many cases withdrawal symptoms can be safely and successfully managed without medication in a quiet, safe, supportive environment, with counselling, reassurance, and social support from non-medical staff to manage withdrawal symptoms. For safety reasons, such facilities usually have ready access to medical assistance in the event of one of the rare life-threatening complications of alcohol withdrawal, though transfers to specialist medical care are hardly ever necessary. In one Australian series of over 4000 patients, for example, less than 0.5% of cases required hospital care for acute alcohol*



*withdrawal. Deaths during alcohol withdrawal are now very rare.*

*Inpatient medically assisted detoxification is needed by those at greatest risk of life-threatening delirium tremens or seizures: those with a previous history of either symptom, those with severe symptoms on the current presentation, or those with concurrent medical or psychiatric disorders that may complicate their management. The preferred agents for minimising withdrawal symptoms are long-acting benzodiazepines, either alone or with other medications such as clonidine and beta-blockers. Suitable regimens are well described elsewhere. It is generally recommended that all moderately to severely dependent drinkers who are undergoing withdrawal (including those in “non-medical” detoxification programmes) should also be given doses of thiamine as prophylaxis against Wernicke’s encephalopathy.*

The particular comments about the value of outpatient detoxification have to be interpreted in the context of whether adequate outpatient programmes are in place.

In the case of opioid detoxification, Mattick and Hall (1996) state (page 99):

#### **Setting for opioid detoxification**

*There is more reason for choosing inpatient rather than outpatient detoxification for opioid dependence. Several investigators have found inpatient detoxification to be superior to outpatient detoxification in terms of the proportion of patients who complete the process; in one study, rates of 81% and 17%, respectively, were achieved. However, others have reviewed retention rates in studies of inpatient and outpatient detoxification and concluded that the completion rates differ substantially, clearly favouring inpatient programmes, with outpatient retention rates of about 20% and inpatient rates between 50% and 77%. It may be the case that opioid-dependent people are more likely than alcohol-dependent people to live in*

*environments (e.g. with other opioid users) that are unsupportive of detoxification and abstinence, and hence are less likely to complete outpatient detoxification. The interpretation of these studies is complicated by the fact that the intensity of intervention and support has typically been greater in the inpatient than in the outpatient setting.*

More recently, the evidence base for inpatient opiate detoxification has been reviewed for the UK National Treatment Agency by Day who was also one of the authors of the 2005 Cochrane Review on “Inpatient versus Other Settings for Detoxification for Opioid Dependence”. The authors concluded that only one study met the rigorous inclusion criteria applied to such reviews. The published data from that study allowed a deduction that 70% of participants in the inpatient group were opioid-free on discharge compared with 37% in the outpatient group, although the numbers involved were too small to really provide good evidence about outcomes or cost-effectiveness. In his more detailed analysis *Opiate Detoxification in an Inpatient Setting* for the NTA in 2005, Day concluded that:

*The rates of successful completion of opiate detoxification are generally higher in studies carried out in inpatient settings than in outpatient settings. There is a degree of consensus about the type of client who may benefit from inpatient treatment including those with complex needs and those in situations where residential treatment is required for medical or social reasons. Inpatient treatment can also be beneficial for more stable patients, and although it is more expensive than community-based treatment options, the higher costs are at least partially offset by improved detoxification completion rates in the inpatient setting. Detoxification and other interventions in an inpatient setting can therefore be cost-effective.*

The factors that influence the likelihood of treatment success and improved outcomes include: the length of stay; the linking of detoxification with rehabilitation and aftercare; and the provision of treatment in specialist facilities.

## Specialist versus general settings

The mapping exercise of existing inpatient provision in Chapter Four suggests that the use of non-dedicated or non-specialist facilities for alcohol and drug detoxification is relatively common in Ireland. A study by Strang and colleagues in the UK (1997) has provided evidence that this is not the most effective use of resources. They found that admission to a specialist inpatient drug-dependent unit compared to a general psychiatric ward was associated with a greater completion of detoxification and a greater likelihood of opioid-free status at two and seven months' follow-up.

The SCAN Consensus Document (2006) noted that the disadvantages of general ward-based services compared to specialist services included: fewer beds per service; lower bed occupancy; shorter planned and actual admission periods; greater likelihood of being closed or unavailable; less input from specialist staff; and a narrower range of available medical and psychological treatment options.

## Length of Stay

The large-scale outcome studies have shown that patients who received less than 90 days of treatment (inpatient or outpatient) did less well than those receiving more than 90 days. The UK NTORS study reported that a period of at least 28 days in inpatient or short-stay rehabilitation programmes was associated with the greatest chance of abstinence.

## Provision of Rehabilitation following Detoxification

Day notes that detoxification can be problematic if it is not integrated into a comprehensive treatment system. The risk of accidental overdose with opioids is increased immediately after a period of detoxification. Treatment outcomes were significantly better among those who completed detoxification and went on to spend at least six weeks in a recovery and/or residential rehabilitation unit (Ghodse et al 2002). MoCDM (2006) emphasises that:

*Continuity of care is essential for preserving gains achieved in residential treatments. Therefore there is a compelling argument for providing, for suitable patients, inpatient detoxification beds attached to residential rehabilitation units (provided that there are adequate medical supports). Other patients need detoxification first in an addiction specialist inpatient unit (e.g. because of severity and complexity) but this still requires significant strengthening of the links with residential rehabilitation provision to ensure the seamless transition of clients between the two.*

The working group wholeheartedly endorses the idea that transition from detoxification (wherever achieved) to residential rehabilitation should be seamless so as to avoid destabilising waiting periods and lack of continuity in care. A recent report (Mark *et al* 2006) which looked at factors affecting readmission after detoxification noted that engaging patients in post-discharge treatment resulted in improved drug abstinence, reduced readmission rates and increases in time to readmission.

A follow-up survey of clients who had attended Keltoi<sup>13</sup> (a therapeutic residential facility within the Dublin North East Region of the HSE) found that 51% were abstinent from all drugs including alcohol, while 60% were abstinent from all illicit drugs.

## Residential treatment for those with alcohol-related problems.

MoCAM highlights the newer evidence which challenges the traditional view that outpatient treatment is more cost-effective than residential services. A number of studies (five) reported a significantly better outcome for residential over non-residential while seven studies reported a general equivalence. Other studies have shown that highly alcohol-dependent individuals benefited more from inpatient involvement as did clients with cognitive impairment. MoCAM notes the evidence that

<sup>13</sup> Personal communication to the Working Group from Brendan McKiernan, Keltoi, 30th January 2007.

residential treatment is of greater benefit for those with more severe alcohol problems or with co-morbidity. This mirrors the evidence that for substance users in general, those with the “greater social deterioration, less social stability and higher risk for relapse benefit more from residential treatment” (MoCAM 2006).

### **Client - Treatment matching**

There is widespread acceptance that matching clients to treatment is a good idea even though the evidence base does not provide complete backing for the concept. The evidence is, however, supportive of the effectiveness and efficiency of reserving the more intensive services for patients with the more severe problems. The research literature indicates that residential and inpatient programmes are more suitable for those who require more intensive services because of the severity of their drug/alcohol and other problems. There is a belief that clients should be offered less intensive interventions initially and those who fail to respond be subsequently offered more intensive interventions. But it is important to point out that it is the needs of a particular client that are the important determinant of the level of intervention made available to them at each stage of what is now referred to as their “treatment journey”.

The working group notes that experience (national and international) points to a number of criteria which can be used to determine if a particular individual will require and/or is likely to obtain particular benefit from inpatient provision. These are set out below:

#### **Patient/Clients for whom inpatient detoxification is indicated**

##### *Alcohol*

The following criteria indicate a need for inpatient approaches:

- Home detoxification attempt failed
- Risk of suicide
- Epilepsy
- Confused or hallucinatory state
- Poor home environment
- Acute physical or psychiatric illness

- Evidence of Wernicke’s Encephalopathy
- Confusion, staggering gait
- Uncontrolled eye movement
- Coma, low BP, hypothermia
- Unexplained neurological signs
- Injectable Thiamine needed

##### *Drugs other than alcohol*

- Those dependent on more than one drug
- Physical complications e.g., cardiac conditions associated with cocaine
- Co-morbidity/Dual diagnosis
- History of complications during previous withdrawals
- Chaotic polydrug use
- Pregnant women
- Patients who have failed outpatient withdrawal
- Those unlikely to cope with outpatient withdrawal due to isolation, homelessness, or lack of family support.

In addition, residential services may also be necessary for socially stable individuals who do not have co-existing medical or psychiatric conditions, but who would benefit from psychological and social respite by removing them from their drug taking environment and supporting them in their drug-free functioning. (Gossop, 2004)

The SCAN Consensus document on *Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service* was drawn up in 2006 by the Specialist Clinical Addiction Network (SCAN) with the UK Department of Health, the NTA and the Royal College of Psychiatrists as additional stakeholders. In the document there is a description of the services a “good” inpatient unit should provide which emphasises that it should have care pathways focussed not only on detoxification (which it refers to as assisted withdrawal), but also on assessment, psychological interventions, harm reduction issues, relapse prevention and notably stabilisation. Such stabilisation procedures can help ameliorate the impact of chaotic drug use particularly of cocaine powder and of crack as well as of other drugs and medication in addition to providing opportunities for

dose titration of methadone or buprenorphine in a secure monitored environment.

The working group draws attention to the fact that two groups will need intensive care on an inpatient basis in a psychiatric unit or an acute medical ward:

- those with serious acute psychiatric problems e.g. acute psychosis; and
- those with a serious medical problem e.g. a life-threatening event resulting from cocaine use.

In these situations it is essential that there is detailed consultation between the addiction psychiatrists and the mental health team in the first case and with the acute medical team in the second. In the first case, the recommendations from the NACD to Government arising from the NACD's commissioned report *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland* (2004) are particularly important. The two key recommendations were: (a) the need to establish a multidisciplinary committee to develop Irish guidelines for managing dual diagnosis; and (b) that any patient in receipt of a valid prescription for methadone prior to admission to a psychiatric facility should be continued on that prescription while under psychiatric care.

In conclusion, the working group endorses the concept of the Four-Tier Model of Care for both problem alcohol and other drug users. It recognises that an overhaul/restructuring of services for chemically dependent individuals in Ireland is necessary to allow for the development of *Tier 4* services of the inpatient/residential type which it envisages as a result of its deliberations. The group draws attention to the documented advantages of inpatient services in improving outcomes for clients, while noting that not every individual will require such services on their treatment journey to recovery.

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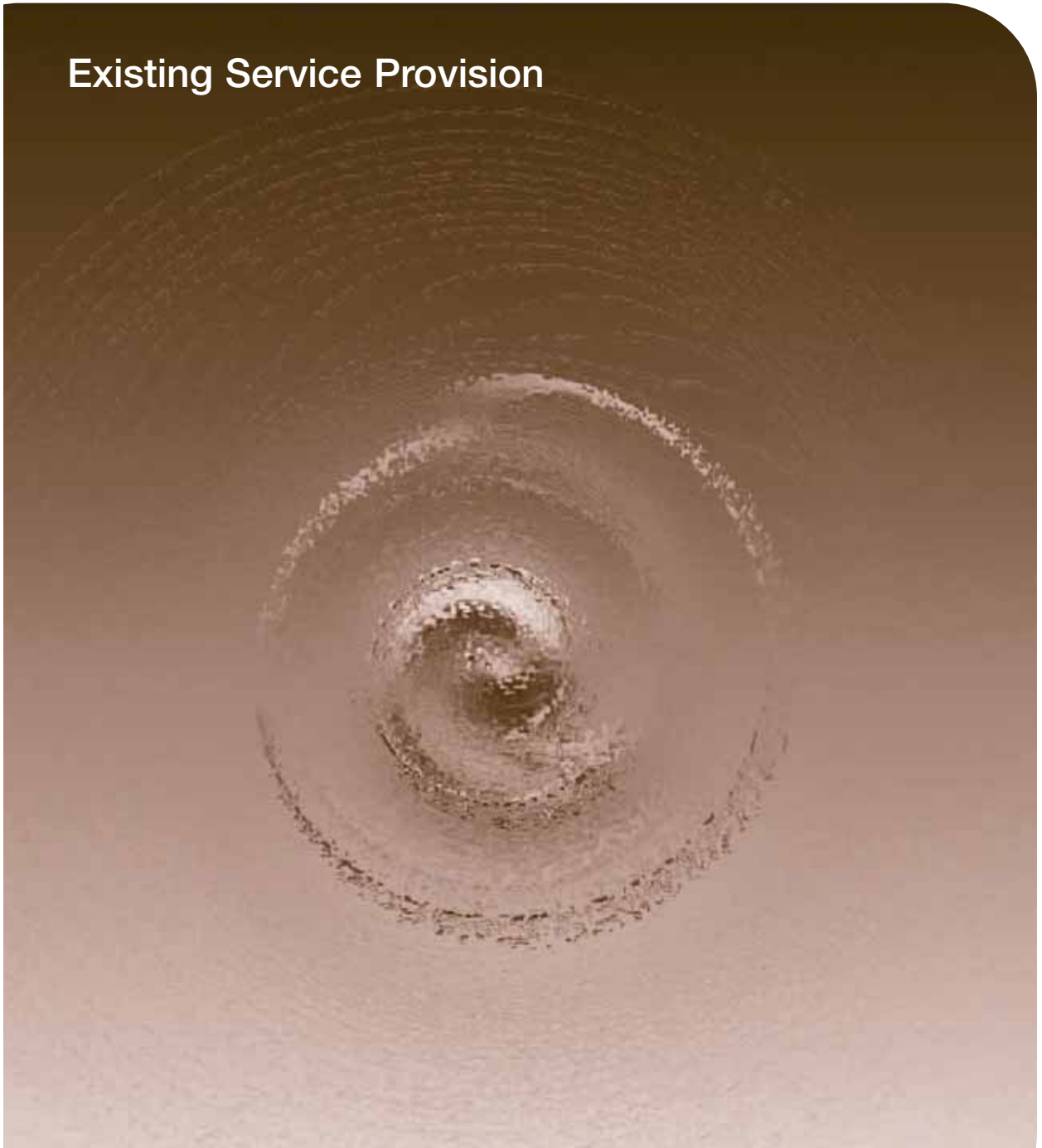
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## Chapter 4

### Existing Service Provision



The Terms of Reference provided by the HSE to the Working Group on Residential Rehabilitation requested a detailed analysis and overview of known current residential treatment facilities offered to those affected by problem drug and alcohol use in Ireland. The Terms of Reference also supplied the working group with the following classification of residential treatment/rehabilitation modalities known to be on offer:

- i. Stabilisation Units;
- ii. Community-based Residential Detoxification Units;
- iii. Medical Detoxification Units;
- iv. Residential Rehabilitation; and
- v. Step-down/Halfway accommodation.

The working group discussed the suitability of this classification framework and concerns were expressed that the framework does not fully reflect the complexity of service provision or the overlap between modalities. For example, there are no stand alone stabilisation units – rather, there is a small number of beds available for the stabilisation of drug users in medical detoxification units; in one unit these are mainly reserved for pregnant drug users.

The classification of all rehabilitation programmes into one category “residential rehabilitation” is viewed as inappropriate by the working group as some services are more focused on rehabilitation and others more on treatment, depending on the physical and mental health needs of their clients. Most notably, the working group saw a distinction between residential rehabilitation services, which focus on helping the client gain an insight into the mechanics of addiction and its role in their lives and those which focus on helping the client develop the living skills needed to live a drug free lifestyle.

Services in the residential rehabilitation category also differed in the range of abstinence-focused approaches and philosophies they provided, such as the 12 step/Minnesota Model, and Therapeutic Communities.

After some discussion, however, the working group maintained the classification system given in the ToR

while noting its shortcomings, but the group recommends the development of an updated directory of rehabilitation services based on a more comprehensive classification of the rehabilitation modalities currently available. The group also noted that new thinking on client-centred care is likely to result in the development of further innovative rehabilitation approaches.

### **Methodology**

A preliminary list of services providing residential treatment and rehabilitation for drug and alcohol users had been prepared by the National Drugs Strategy Team for consideration by the working group. This list has since been amended as service provision was checked and verified using a range of additional sources such as directory and website searches; published reports from the residential services; feedback from members of the HSE working group; telephone survey of services by the technical assistants to the group; and data from the National Drug Treatment Reporting System (NDTRS). Additional information on the provision of drug and alcohol treatment within the general and psychiatric hospital services was provided by the co-ordinators of the Hospital Inpatient Enquiry (HIPE) and National Psychiatric Inpatient Reporting System (NPIRS) databases.

The estimation of service capacity is calculated using the number of beds and average length of stay in each service and is based on an optimal 85% occupancy rate of beds – the benchmark against which the need for additional bed capacity in Ireland is assessed (DoHC, 2002). The figures given are best estimates. However, it should be noted that in practice a number of factors affect the annual throughput of clients through these residential services. For example, the lack of sufficient detoxification facilities so that participants are drug free on entry; the staffing levels available; and the level of non-completions of a rehabilitation/treatment programme. The estimation of the current number of rehabilitation beds is also marginally affected where the service also treats people with gambling problems and eating disorders as beds are not necessarily dedicated to a particular addiction and information on the proportion of

admissions relating to drug and/or alcohol problems is not readily available. Consequently, bed numbers and capacity may be somewhat over-estimated where services deal with a broad spectrum of addictions.

Many rehabilitation services in theory deal with both drug and alcohol problems, but in practice a higher proportion of beds deal with alcohol-related problems. The proportion of bed numbers, and resulting capacity, dedicated to the treatment of a particular drug is not fixed but depends on referrals etc. Consequently, the mapping exercise has highlighted those services which deal with one substance only. However, this should not be taken to imply that the beds in other services are equally available to drug and alcohol users, notwithstanding that the clients may be polydrug users and that the distinction between drug and alcohol beds may be a false dichotomy.

Similarly, some services are gender specific and this is highlighted in the estimation. But again, the remaining services are not necessarily equally available to either men or women.

Overall, there is a poor distribution of services throughout the regions (see Map 1). There are no dedicated residential stabilisation or detoxification beds (either residential community-based or hospital-based) outside of the Dublin area<sup>14</sup>. And, there are no dedicated drug or alcohol residential services in counties Cavan, Laois, Leitrim, Longford, Offaly, Roscommon, Sligo, Tipperary North or Westmeath – which have a combined population of over half a million people (537,409) (Census 2006).

## Commentary and analysis

The resulting overview of current residential service provision (see Table 1) estimates that there are:

- ☞ 2 community-based residential detoxification services with 15 beds and an estimated capacity of 170 clients per annum;
- ☞ 2 medical residential detoxification units with 17.5 beds and an estimated capacity of 157 clients per annum. In addition the MDUs reserve a small number of beds (5.5 in total) for stabilisation purposes; these have an estimated capacity of 87 clients per annum;
- ☞ 28 residential rehabilitation services with 634.5 beds and an estimated capacity of 3,652 clients per annum;
- ☞ 14 step down/halfway houses with 155 beds and an estimated capacity of 368 clients per annum.

<sup>14</sup> Some residential services conduct detoxifications if required, but this is the exception rather than the rule.

**Table 1: Estimation of current capacity of national drug and alcohol residential services, 2006**

<b>NATIONAL SUMMARY</b>		
(Population 4,234,925 - Census 2006)		
<b>There are no dedicated residential services in counties Cavan, Laois, Leitrim, Longford, Offaly, Roscommon, Sligo, Tipperary North or Westmeath.</b>		
SERVICE TYPE <sup>15</sup> (N.)	NUMBER OF BEDS <sup>16</sup>	ESTIMATED ANNUAL CAPACITY <sup>17</sup>
<b>Stabilisation Service</b> [Note: these are not stand alone units but beds reserved within the two MD Units]	<b>5.5</b>	<b>87</b>
<b>Community-based Residential Detoxification</b> (2)	<b>52</b> 53% (n=8) alcohol only	<b>170</b> 69% (n=118) alcohol only
<b>Medical Detoxification Unit</b> (2)	<b>17.5</b>	<b>157</b>
<b>Residential Rehabilitation</b> (28)	<b>634.5</b> 31% (n=197) alcohol only 12% (n= 76) men only 0.04% (n=28) women only	<b>3652</b> 36% (n=1310) alcohol only 3% (n=106) men only 1% (n=24) women only
<b>Step-down/Halfway House</b> (14)	<b>155</b> 76% (n=118) men only 10% (n=15) women only	<b>368</b> 78% (n=286) men only 13% (n=47) women only
<b>General and Psychiatric Hospitals</b> (HIPE and NPIRS databases, 2005)	79 16% (n=13) illicit drugs <sup>18</sup> 84% (n=66) alcohol via psychiatric services	3,825 (NPIRS) 718 (HIPE) (cases not individuals)

<sup>15</sup> As per Terms of Reference

<sup>16</sup> Some services also treat gambling and eating disorders. However, the number of beds dedicated to these is not set, hence the number of beds and the estimated annual capacity is probably overstated for these service as the estimation assumes all beds are available for drugs or alcohol treatment.

<sup>17</sup> The estimated annual capacity of services, is calculated by dividing the number of days (or weeks or months as appropriate) per year by the duration of programme (using the mean duration if range is given) and multiplying this figure by the number of beds (using the mean number of beds if range is given). 85% of this figure is then calculated to reflect the occupancy rate of services.

<sup>18</sup> This provision may not be additional to that included under Medical Detoxification Units (number 3 above) as one of these services also report throughput to the HIPE database.





## The treatment of drug and alcohol problems in General and Psychiatric Hospitals

In addition to the specialised provision of drug and alcohol residential services above, services are provided in general and psychiatric hospitals funded by the Health Services Executive.

In 2005, the National Psychiatric Inpatient Reporting System (NPIRS) database recorded 3,007 primary discharge diagnoses for “alcoholic disorder” and/or 818 primary discharge diagnoses for “other drug disorder” from psychiatric hospitals and psychiatric units within general hospitals (Total 3,825).

In the same year, the Hospital Inpatient Enquiry (HIPE) database recorded 718 “principal procedures” conducted in general hospitals for alcohol and/or drug detoxification (n=703) and alcohol rehabilitation and detoxification (n=15).

The geographical location of these hospitals is outlined in *Map 2: General and Psychiatric hospitals treating patients with drug and alcohol problems* and a list of the psychiatric, general and private hospitals involved detailed in Appendix 4.

For the purposes of estimating existing service provision, the working group notes the role, to date, of general and psychiatric hospitals in providing treatment to people with drug and alcohol problems, particularly in areas where there are insufficient specialised services. However, the working group notes the evidence that treating people with drug and alcohol problems in these settings is not best practice and, in the case of the psychiatric hospitals, will not be an option available in the future as a result of the restructuring of the psychiatric services proposed in *Vision for Change*.

An approximate extrapolation from the HIPE data indicates that 13 beds in the acute hospital system are utilised for drug detoxification with an annual capacity of 144 (based on a four-week average length of stay and 85% occupancy). However, this provision may not be additional to the working group’s estimation of current capacity of dedicated residential services as one of the medical detoxification units also reports throughput to the HIPE database.

In the case of alcohol, the number of discharges from psychiatric hospitals and psychiatric units in general hospitals, as reported in the NPIRS, can be used to calculate the total number of bed days attributable to the treatment of alcohol. This gives an approximate figure of 66 beds occupied for alcohol detoxification in the psychiatric services<sup>20</sup>.

### Potential Savings

The working group wishes to draw attention to the potential savings/benefits achievable arising from the reduced use of acute medical or psychiatric hospital beds by substance users, which occurs at present.

1. Providing for treatment in a dedicated facility is a more economic use of health resources as compared to the current system of providing treatment in an acute medical or psychiatric bed. We estimate that approximately €4.4 million is currently being expended by the general hospital sector on drug detoxifications<sup>21</sup>. Using a similar calculation, we also estimate that a further €7.3m is spent on inpatient treatment for alcohol disorders in the psychiatric services<sup>22</sup>.
2. As a large amount of the costs per bed night are fixed costs, these costs are being incurred regardless of the core needs of the patient occupying the bed. It is a well documented issue

<sup>20</sup> N. of discharges x average length of stay (7 days for alcohol detoxification) = Total No. of bed Days - Divided by (365 days @ 85%) = No. of beds used.

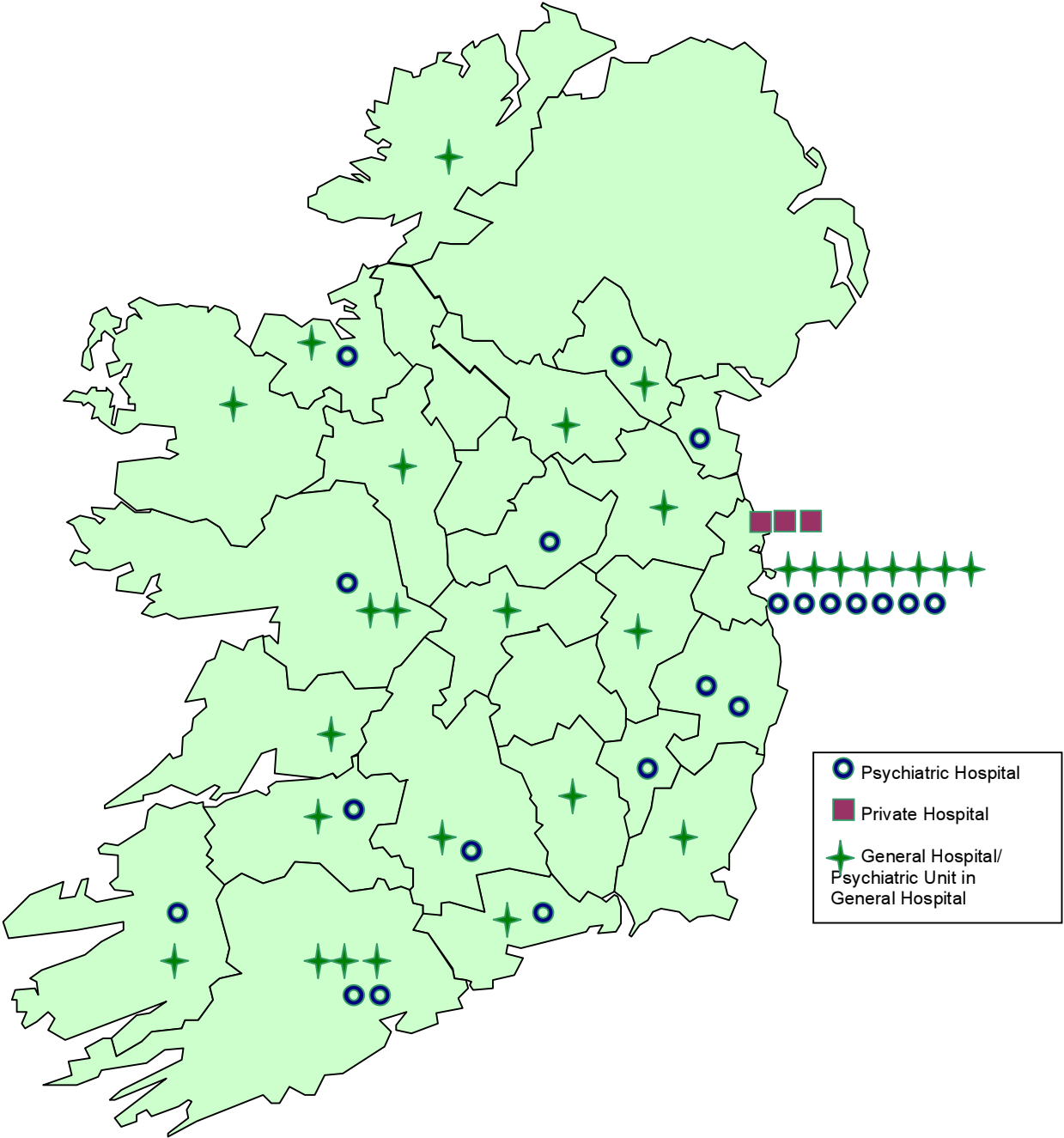
<sup>21</sup> Calculated by multiplying an average cost of an acute medical bed (€1,090 – the estimated cost of an acute medical bed in Dublin ranges from €880-€1,300 per bed night – differences relates to tertiary services which increases costs compared to smaller hospitals) by the number of bed nights (4,033) estimated as being used for drug detoxification in acute hospitals (as per HIPE data) – 13 beds @ 365 days @ 85% occupancy x €1,090 = €4.4m.

<sup>22</sup> Calculation based on 66 beds x 52 weeks @ 85% occupancy x €2,500p.w. = €7.3m. However, the WG notes that the absence of reliable and accurate data, combined with the large number of variables in relation to types of treatment and care across the range of psychiatric inpatient settings, makes it extremely problematic to estimate the cost of a psychiatric bed at present. Consequently, the figure of €2,500 per week (provided by the HSE and based on available information at the time) can only be considered notional.

that there are large demands on acute beds in Irish hospitals. Therefore, using acute facilities for treatment of patients who would be more appropriately treated in a dedicated inpatient detoxification unit is an inappropriate use of scarce resources and a missed opportunity for an acute elective patient to be treated.

3. The provision of dedicated facilities provides better outcomes for patients, therefore treatments in these facilities provides an enhanced service for patients and also, as patients are less likely to require repeat detoxifications, these costs will not be incurred repeatedly.

**Map 2<sup>23</sup> : Location of General and Psychiatric Hospitals reporting drug and alcohol treatment, 2005**



<sup>23</sup> Blank map drawn by Conor Teljeur, SAHRU, TCD

## Key issues

### Specific services

A number of the residential services target specific substance problems. Over half (53%) of the community-based residential detoxification beds and almost a third (31%) of the residential rehabilitation beds are for clients with alcohol problems only. The substance-specific nature of existing residential services is captured in data from the National Drug Treatment Reporting System<sup>24</sup> (NDTRS). Of the 3,407 reported admissions to residential drug and alcohol services in 2005<sup>25</sup>; three-quarters (76%) reported alcohol as their main problem drug; whereas just over one-fifth (21.5%) reported illicit drugs as their main problem drug. The increasing levels of polydrug use being reported by clients attending community-based drug treatment services (Long et al, 2005) does not yet seem to have impacted on residential services; almost two-thirds (65%) of admissions reported to the NDTRS indicated a problem with one substance only; whereas over one third (35%) had a problem with more than one substance. However, this may reflect the substance-specific nature of the existing services.

A number of residential services are gender specific: 12% of residential rehabilitation beds are for men only; and less than 1% are for women only. The gender imbalance in services is most acute with regard to step-down/halfway house services where three quarters (76%) of the beds are for men only; and 10% for women only. Again, this issue is reflected in the NDTRS data where a ratio of three men (75%) to one woman (25%) was reported as receiving treatment in inpatient/residential services in 2005.

The bulk of the services deal with adults only and there are only two specialised services for adolescents, namely Aislinn and Cara Lodge.

### Inadequate level of residential services

Data submitted to the working group by the National Drugs Strategy Team, on residential treatment and rehabilitation needs identified in Regional Drug Task Force plans indicated the need for: detoxification facilities; general rehabilitation services; rehabilitation services for women; and child-friendly residential services; both alcohol and drug services for under 18-year-olds; services to accommodate street drinkers; and respite and aftercare/halfway houses.

The working group notes the inadequate level of residential services throughout the country, in particular, detoxification services; quality assured rehabilitation services; public residential services; and services for special need groups – such as homeless people, young people, women with children, and new/ethnic communities.

The working group notes that access to residential services may be further limited to those in areas outside of existing services' catchment areas, reinforcing the need for a regional spread of services.

### Community-based services

The Four Tier Model of Care for people with drug and/or alcohol problems, described in Chapter Three of this report, provides a framework for grouping services into tiers which correspond to the level of need of clients. However, for such a model to be fully effective, all tiers need to be fully operational. A deficiency in one or more tier will have a knock-on effect on others. For example, the lack of GP and/or community supported detoxification and residential detoxification facilities is seen to impact on the ability of community-based alcohol counselling services to cater for the needs of their clients. A submission from the Statutory Alcohol Services to the working group noted that one-fifth of their clients would benefit from an inpatient detoxification but no such service was available to them.

<sup>24</sup> The National Drug Treatment Reporting System (NDTRS) is an epidemiological database recording socio-demographic and drug use information on the number of cases attending treatment for drug, and more recently alcohol, problems. The majority, but not all, residential treatment services report to the NDTRS; the database also includes drug users receiving treatment in a small number of acute hospitals.

<sup>25</sup> This includes a small proportion of cases reported by acute hospitals and inpatient psychiatric units (13%, n=456) to the NDTRS in 2005 a further 3% (n=90) treated in inpatient psychiatric units where addiction was secondary to mental illness). Note, not all residential services report to the NDTRS.

The working group noted that where there is an inadequate provision of community-based services (such as drug services outside of the Dublin area and alcohol services nationwide), the demand for residential services is high.

In addition, the working group are of the view that an increase in the number and quality of community-based services would attract more people to seek help (for example, a crèche would encourage more women to attend services) and in turn lead to an increased demand for these services and, consequently, for residential drug and alcohol services.

The working group recognises that recommendations on non-residential community detoxification are not within its remit but notes there is significant capacity for detoxification outside of residential programmes by local GPs and drug treatment centres within the community.

GPs working within the community with Level 2 training could also work with community-based residential detoxification units on a part-time basis to provide an inpatient detoxification service (as happens with City Roads/Equinox in the UK). The working group recommends that GPs from the community with Level 2 training be resourced to work within residential programmes to provide residential detoxification.

The working group believes that the lack of adequate community-based services will have a knock-on effect on the ability of residential programmes to function at an optimum level as such services can enable clients to be stabilised to a level that will allow them enter residential programmes. As a result, the working group suggests that the issue of community-based services urgently needs review in order to avail fully of the potential for making safe and effective detoxification more accessible.

### **Range of services**

Voluntary organisations are the main providers of residential drug and alcohol services. The working

group notes that this has implications for clients in terms of the cost of such a service to those without or with inadequate health insurance.

Notwithstanding the low level of residential rehabilitation accommodation directly provided by the public sector and the fact that the bulk of residential services are provided by the private sector, there is frequently public subvention of such facilities which needs to be reviewed and formalised.

Services are predominantly abstinence-based, following a 12 step/Minnesota Model and/or Therapeutic Community philosophy. Most are spiritually-based.

The working group notes the need for residential services where stabilisation is the goal rather than abstinence.

### **Polydrug use**

Research evidence increasingly shows that polydrug use rather than a problem with a specific drug is the most common scenario of those presenting to the drug treatment services (Long *et al*, 2005). Although, the evidence suggests that polydrug use is more common among people whose main problem drug is an illicit drug, rather than for those for whom alcohol is the main problem drug.

### **Gender**

Residential services are also focused more towards men and, though research data indicates men have higher prevalence rates than women, this trend is seen to be changing rapidly.

### **Dual Diagnosis**

Both the National Drug Treatment Reporting System (NDTRS) and the National Psychiatric Inpatient Reporting System (NPIRS) report the use of psychiatric services for the treatment of drug and alcohol problems (see Chapter Two). However, the implementation of the recommendations of the Expert Group on Mental Health Policy *A Vision for Change* (2006) will see this practice discontinued as:



*individuals [adults and children] whose primary problem is substance abuse and who do not have [other] mental health problems will not fall within the remit of mental health services.*

Mental health teams will care for adults with co-morbid substance misuse and mental health problems where the mental health problem is the primary problem. Specialist substance abuse mental health teams for adults with complex severe substance abuse and mental disorders will be established. The expert group states that beds in acute psychiatric facilities “should not be used for routine detoxification” and goes on to state that “more complex detoxification should take place in acute general hospital facilities”.

### Waiting lists

Data presented to the working group on waiting lists for admission to residential services indicated the inadequate level of service provision. Clients may have to wait, post detoxification, in the community for up to two months prior to admission. Unfortunately, in most cases they relapse and do not make it to the residential rehabilitation service. This is despite the huge investment the client and the service have made in the client getting to the point of successfully completing a detoxification.

Data from the NACD commissioned ROSIE study on treatment outcomes reported that participants in the study reported waiting for inpatient detoxification services, depending on the service attended, from on average 12.4 weeks (n=24) to 9.5 weeks (n=5).

### Staffing

The detoxification and rehabilitation residential services directly provided by the HSE report operating at sub-optimal level due to staff ceilings within the HSE.

Also, community-based detoxification services report difficulty in sourcing support for the medical supervision of detoxification.

### Prison drug treatment services<sup>26</sup>

The issue of drug treatment in prison was considered by the working group. While this issue is not strictly within the remit of the working group, members recognised that *de facto* detoxification and rehabilitation services were provided in prison and that these provided a valuable contribution to the overall level of service provision to drug users.

The Central Treatment List of the number of persons receiving methadone treatment in Ireland notes that 545 people received methadone treatment in prison during February 2007.

The working group noted the need for a through-care service for problem drug users entering and leaving the prison system and noted the high risk of overdose when problem drug users were discharged into the community without a care plan in operation. This has implications for the provision of step-down/halfway house accommodation.

The current Drug Treatment Programme (F5 Medical Unit) in Mountjoy Prison is a seven-week abstinence-based drug treatment programme for nine prisoners. The unit has the potential to cater for 56 prisoners via seven programmes per annum. The working group believes that such a unit has a significant role to play in the overall provision of “inpatient” detoxification and would welcome an expansion of such facilities in prisons other than Mountjoy.

## 4.0 Recommendations on Existing Services

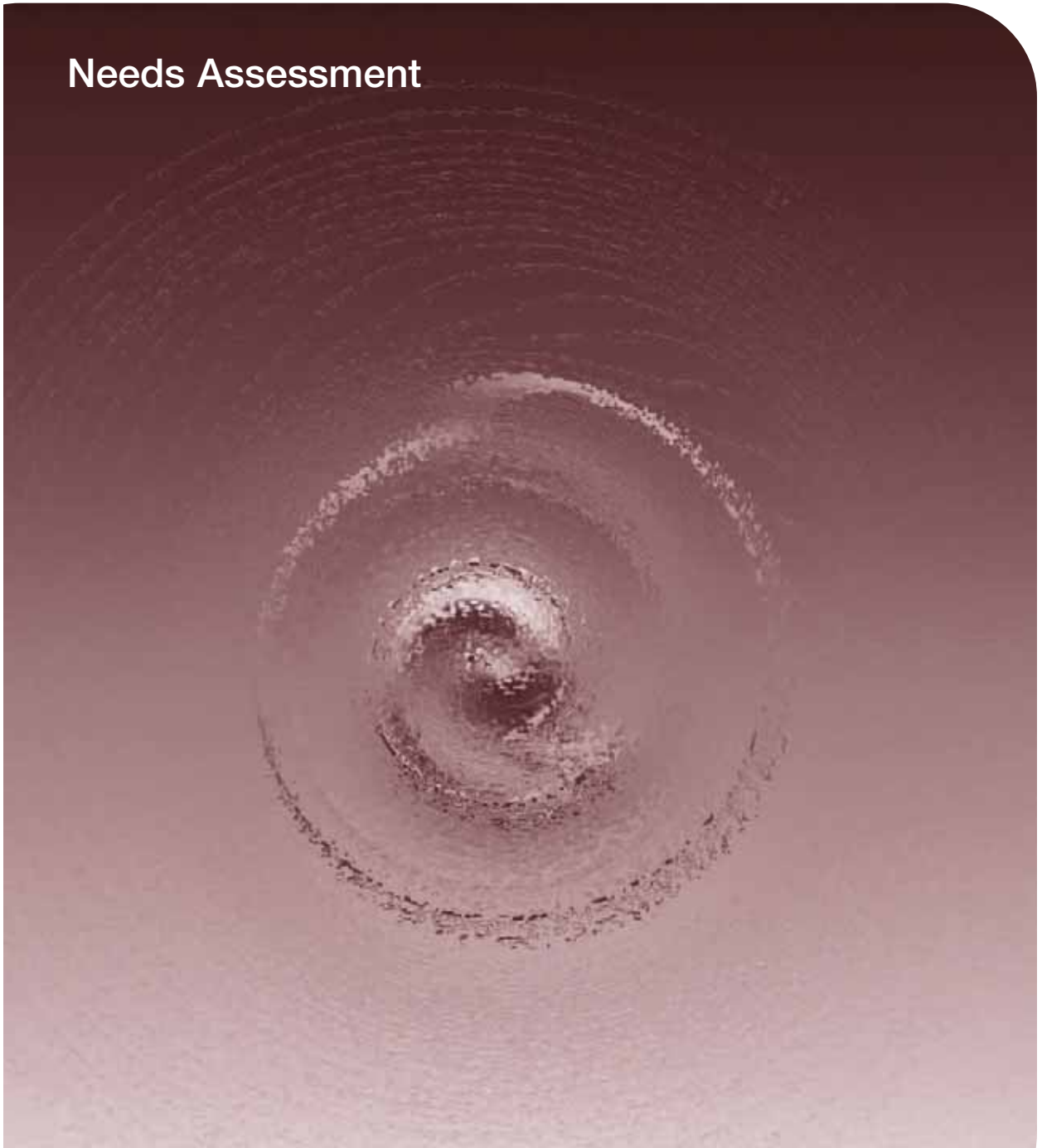
- 4.1 Significant support is needed for the development of drug and alcohol community-based services, including the availability of local detoxification services, as part of the overall four-tier model.
- 4.2 The demand for Tier 4 services should be driven by the needs of clients within Tiers 2 and 3.

<sup>26</sup> Pugh submission to HSE working group on residential rehabilitation.

- 4.3 A mechanism to track progression from treatment services to rehabilitation is required. This linkage can be achieved by use of a unique identifier which we recommend be used for all contacts with drug services to enable integrated care planning in line with the rehabilitation strategy, and so that, with appropriate confidentiality procedures, cross referencing can be carried out.
- 4.4 A regularly updated directory of current residential services detailing programme approach, type of service provided, ethos, number of residential beds, funding profile etc to be publicly available.
- 4.5 The practice of using acute medical or psychiatric beds for uncomplicated detoxifications should be the exception rather than the rule.
- 4.6 Adequate support should be provided by the mental health services for clients with co-morbidity issues in residential drug and alcohol services, and clear pathways to residential mental health services for such clients where necessary, as outlined in the NACD commissioned report on Dual Diagnosis.
- 4.7 Where an appropriate psychiatric service is not available in the catchment area for people with a dual diagnosis, there should be flexibility to refer the person across catchment areas.
- 4.8 There should be a similar national working group to estimate the current capacity of community-based services in order to enhance Tiers 1, 2 and 3 as well as looking at the balance between all four tiers.
- 4.9 With regard to drug treatment services in prison, the following recommendations are proposed:
- i. The provision of accommodation for many prisoners at point of release is important as the first 48 hours following release presents problems in terms of relapse, recidivism and even death. It is recommended that halfway house projects should be set up to support prisoners who are deemed to be vulnerable following release.
  - ii. There is potential within prisons to utilise living spaces to provide drug-free wings with concomitant therapeutic regimes. There are embryonic drug-free wings in St Patrick's Detention Centre and Wheatfield Prison but these require significant resources and co-ordination. The medical unit in Mountjoy has the potential to provide demarcated residential living and associated regimes and these could be used to: provide a relapse facility for the prisoners who are sent back, following relapse, from the drug-free training unit; provide methadone maintenance support programmes and slow detoxification programmes.
  - iii. Other prisons could also provide similar activities. All these activities would need to be underpinned by a case management system that could provide the necessary throughcare. In other words, shared care planning and the provision of integrated care pathways are essential for the management of prisoners. This must be done in a way to ensure clinical confidentiality.
  - iv. Prisons are a neglected setting for the delivery of alcohol treatment programmes and the working group recommends the integration of alcohol with drug treatment programmes within Irish prisons.

# Chapter 5

## Needs Assessment



The working group is required to provide the HSE with an expert view as to the future range, scope, type and method of delivery of residential treatment in Ireland. In doing so the members, as set out in the Terms of Reference, considered those sections presented to it from a draft report from the Working Group on Rehabilitation, set up under the Fifth Pillar of the National Drugs Strategy. The proposal in the draft seen by the Working Group to increase the current number of 23 inpatient detoxification beds on an interim basis (pending the outcome of the report of this group) by an additional 25 will not, in the view of the working group, meet the needs of all those requiring inpatient services because of their drug use. It will not provide any increased response to the needs of those whose primary drug problem is alcohol given the notable lack of alcohol detoxification facilities in many areas, nor will it address the need for residential rehabilitation for those who have been detoxified from alcohol or other drugs, either as inpatients or on an outpatient basis.

The group notes that many substance users can and will be successfully treated on an outpatient basis or, in some cases, within the community. This will include assisted withdrawal from most drugs. However, it is well recognised that many others will meet the criteria for admission for assisted withdrawal on an inpatient basis. Others will require stabilisation and respite, while a number will require residential rehabilitation interventions of variable duration. It is important to note that what some services view as rehabilitation is seen by other services as a treatment response.

### **Methods for measuring needs**

Despite the requirement for effective needs assessment models, there is limited literature on how to measure the need for substance misuse treatment. Because the literature on measuring the need for inpatient treatment is limited, the group has considered a range of formulas used in other countries to see if any of them might be appropriate for Irish needs. Much of the international literature has been reviewed by the National Treatment Agency in the UK and the Group has drawn heavily on the material in those NTA documents.

One method of attempting to measure need based on demand is the Prevalence: service utilisation ratio (PSUR) method, although this has been applied primarily to alcohol populations. According to this model (Phillips *et al*, 2004), around 10% of the problem-drinking population are estimated to present to treatment services annually and 10% of this group (or 1% of the overall problem-drinking population) will require inpatient treatment. The problem with such a model is it doesn't measure hidden demand for treatment; it is difficult to define problem drinking and it is not clear how this alcohol model can be applied to illicit drugs.

One alternative would be a "systems approach" as it measures treatment by combining existing information about treatment demand (obtained through measures such as waiting lists and number of referrals relative to number of admissions) with "system" indicators of harms accrued in particular areas, such as liver disease, crime or drug-related deaths

The systems approach is based on what should be available and is not solely reliant on what currently exists. In an Irish context, data on drug-related deaths, for example, is incomplete and while the National Drug-Related Death Index currently being developed by the Alcohol and Drug Research Unit (formerly the Drug Misuse Research Division) of the Health Research Board will provide invaluable data, it will not be available for some years.

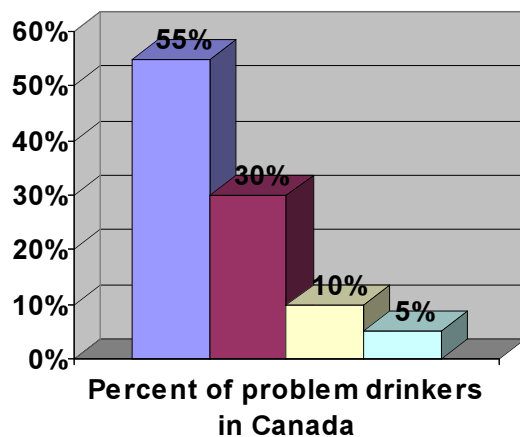
Internationally it is accepted that the efficacy of each approach is contingent on available data and resources. As a basic minimum, Ford and Luckey (1983) identified four key stages for assessing need:

1. Determine the geographic size of the population to be served
2. Estimate the number of problem users within each population group
3. Estimate the number of individuals from Stage 2 that should be treated in a given year (defined as the demand population)
4. Estimate the number of individuals from Step 3 that will require some service from each component of the treatment

system – in this instance from residential treatment.

Using this approach for assessing alcohol related need, Rush (1990) used existing data from a number of Canadian provinces to extrapolate that 15% of problem drinkers in Canada can be considered to be the treatment “target” group in any given year. This estimate was based on alcohol-related mortality data, national population survey data on drinking and population data on average consumption levels. The problem group in this area was calculated as 8.6% of the drinking population who would be referred to specialist services.

Of the 8.6% of the drinking population, the requirement of specialist services breaks down as follows:



Of this group, 55% will be referred to outpatient services, 30% to day treatment, 10% to short-term residential treatment and 5% to long-term residential treatment. However, around 20% will drop out from each treatment modality before completing these treatments. Furthermore, around 4% of the original group will be directly referred to services (i.e. after emergency or criminal justice attendance), resulting in a total of around 950 clients (or 9.5% of the original 10,000) who will actually access specialist services, with the majority of these most appropriately dealt with in outpatient settings. The key point is that routes to and through treatment are not necessarily consistent or ubiquitous and are inevitably interlinked. Again, this method of assessing need is limited by the viability of available data sources, both to measure the demand for existing treatment services and for testing the level of unmet need that does not take the form of explicit demand. It is also unclear whether this approach is also valid for those using drugs other than alcohol.

### Systems-based approaches

Systematic assessment of drugs-related treatment need has been conducted infrequently in England and much of the evidence for good practice derives from the alcohol field. In relation to alcohol services, Godfrey, Hardman and McKenna (1993) suggested the use of multiple sources for attempting to assess the “in-need” population, using three broad data types to assess overall need:

1. Direct measures of substance consumption.
2. Extrapolation from existing survey work.
3. Using substance-related problems as indicators.

Godfrey *et al* included statistics on drinking and driving, drunkenness offences, alcohol-related mortality and morbidity, sickness absence and accidents at work. The group notes that much of this data is not routinely available in Ireland.



## Local needs assessments and reports

Moreover, extrapolating data from alcohol to drugs can be dangerous, given the limitations of research in this area. Therefore, one of the key approaches considered was to examine the existing locally-conducted, drugs-focused needs assessments in order to identify useful data and innovative methods. This approach was disappointing, yielding relatively little systematic work. The dominant theme highlighted in these reports is the need for additional provision of local residential treatment facilities, particularly for inpatient detoxification (IPD). This overall need is supplemented by concerns about the limitations of provision for particularly vulnerable populations, especially women, those with co-morbid mental health problems and the under 18s.

## Data limitations in Ireland

In seeking to adapt international models to the Irish context, the group were faced with a lack of appropriate data to implement the needs assessment models described above as well as others listed in the literature. As a crude example of the impact of different models, it is worth noting that adopting one UK approach would result in an estimated need for 120 beds nationally while another (based solely on opiate users and on length of stay) gives bed numbers between 102 and 143.

The group found that existing Irish data sets on prevalence, treatment demand, drug and alcohol-related morbidity and mortality are insufficient to allow the use of the more advanced models of Needs Assessment for IPD and Residential Rehabilitation.

The range of drugs research in Ireland has improved greatly in the last five or so years largely through the research commissioned by the National Advisory Committee on Drugs (NACD) and reports from the Alcohol and Drug Research Unit<sup>27</sup> at the Health Research Board. Studies such as the 2002/3 General Population Survey on Drug Use (NACD/DAIRU, 2004) and the NACD commissioned 2000/1 Capture-Recapture Study on the prevalence

of opiate use (Kelly *et al* 2003) provide us with an understanding of the level of use and problem use of opiates in Ireland (see Chapter 2). The updating of these studies, (which is being undertaken in 2007), will give greater clarity on the changes in patterns and trends in drug use. In addition, the working group recommends that attempts be made to collect data which is currently lacking in an Irish context (e.g. absenteeism and accidents at work due to alcohol or other drugs or a combination of both), so that ongoing needs assessment exercises are conducted on a firmer knowledge basis.

## Model adopted by the Working Group for assessing inpatient need

The working group took particular interest in an alternative estimation model proposed for the UK by The SCAN Consensus Project on the *Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service*. This recommended that a ratio of 15 inpatient beds for service users with alcohol or other drug problems, per half a million total population was appropriate (p. 52).

This estimate is for an Inpatient Unit (IPU) i.e. a medical facility with a multidisciplinary team which provides assessment, stabilization and other supportive interventions and/or assisted withdrawal. The population served by an IPU will depend on the local level of alcohol or drug problems, the level of community and other medical services, the degree of integration of local care pathways.

The ratio of 15 beds per half a million total population is in line with recommendations made by the Royal College of Psychiatrists in 2002 of three beds per 100,000 total population and is similar to that put forward by Dr Mai Mannix for the former Southern Health Board.

In Ireland, this would amount to 127 IPU beds for a population of just over four million, based upon the 2006 Census. The working group therefore recommends that half (n=63) of these beds be allocated to the treatment of those who are primarily illicit drug users and the remainder (n=64) for the

<sup>27</sup> Formerly the Drug Misuse Research Division

treatment of those whose primary drug is alcohol (as recommended in the SCAN Consensus document).

The concept of an inpatient unit as set out in the SCAN document is for the provision of services with 24-hour cover, seven days per week from a multidisciplinary clinical team under the leadership of a consultant in addiction psychiatry or other medically qualified substance misuse specialist. Based on this concept, the deficit in detoxification beds can be stated as 104. This is composed of 64 beds for alcohol detoxification and 40 additional beds for drugs other than alcohol. The value of community-based residential detoxification services in meeting the needs of clients at present and in the future is well recognised by the group but we note that such beds do not fulfil the criteria for IPU beds as set out in the SCAN report and should not be included when calculating the additional bed capacity required.

In the case of residential rehabilitation, the working group believes that bed provision should be dictated by the need to ensure that transition from detoxification (inpatient or outpatient) should be seamless and that a waiting list between these phases is to be avoided at all costs. Members recognised that the risk of relapse was high if there was any delay between completion of a detoxification programme and entry into residential rehabilitation and that relapse to opiate use in particular brought with it a greatly increased risk of a fatal overdose. In addition, Ghodse et al (2002) provide evidence that outcomes can be improved with seamless progress from the drug withdrawal phase into the rehabilitation phase of recovery. Accordingly, the working group recommends that a residential rehabilitation place be available for each person undergoing inpatient detoxification. The number of places should also provide for those who have undertaken a community-based or outpatient assisted withdrawal/detoxification programme and who are deemed likely to benefit from being separated from drug-using networks or require admission for other social or medical reasons.

It is the view of the group that there is an obligation on the State to provide detoxification and rehabilitation facilities based on the principle of need. The issue of funding of beds is beyond the remit of this group.

Based on these recommendations the following estimate of future need was calculated:

### Table 2: Estimate of Future Need

63 detoxification beds for primary drug users undergoing an optimum 4-week detoxification (operating at 85% occupancy) can provide detox for 696 people per year.

In turn, these 696 people transferring on to a 13-week<sup>28</sup> residential rehabilitation programme (operating at 85% occupancy) would require 205 beds for drug rehabilitation.

64 detoxification beds for primary alcohol users undergoing a 1-week detoxification (operating at 85% occupancy) can provide detox for 2,829 people per year.

In turn, these 2,829 people transferring on to a 6-week residential rehabilitation programme (operating at 85% occupancy) would require 382 beds for alcohol rehabilitation.

This level of provision is appropriate for the demand arising from a policy of seamless transition from an inpatient detoxification programme into residential rehabilitation. However, this will not meet the demand for access from clients seeking admission to residential rehabilitation from outpatient detoxification programmes. Information provided by group members shows that the existing level of such demand is considerable but highly variable ranging from 50% of overall intake into one service to 90% of intake in the case of a second. This variability makes it difficult to specify a precise

<sup>28</sup> Length of stay based on international best practice.

figure for the additional accommodation which is required to meet that particular need. The impact of the expansion of inpatient services as proposed by the group on the future level of demand from “outpatient” clients is also uncertain at this stage. Regional diversity in service needs and development as well as differences in the primary drugs involved makes an accurate assessment of the needs of this particular client group difficult at present.

Based on the limited data available and the need to ensure to the maximum extent a seamless transition from detoxification into residential rehabilitation for those whose care plan requires it, the Working Group recommends that a minimum of 300 rehabilitation beds be added to the overall figure above to cater, in part, for the demand from clients

coming from outpatient programmes. The group, concerned that this initial additional provision may prove to be inadequate in practice, recommends that the figure be carefully and regularly monitored with a view to remedial action being taken rapidly. It is essential that waiting lists of those completing outpatient detoxification and then seeking admission to residential units should not develop. Any such review of provision should be separate from the overall review of inpatient and residential provision recommended by the group later in this chapter.

Given the limitations of the data on which the working group had to base its estimates, the group acknowledges the appropriateness of stepwise provision in line with monitoring of need.

**Table 3: Current and Recommended Estimate of Need**

Bed Type	Current Provision	Estimated Need	Deficit
Stabilisation Services	5.5	127 (IPU)	104 (64 for alcohol detoxification; 40 for drugs other than alcohol)
Community-based Residential Detoxification	15		
Medical Detoxification	17.5		
Residential Rehabilitation	634.5	887 (205+382+300)	252.5 <sup>29</sup>
Step-down, Halfway house	155	296	141
General and Psychiatric Hospitals	79 <sup>30</sup>	N/A	N/A

In highlighting the deficit of 356.5 beds (104 IPU and 252.5 rehabilitation) the working group notes the estimated 66 beds currently in use for alcohol and drug problems in the psychiatric hospitals and units and the necessity of ensuring that the current resource involved continues to be applied when remedying the deficit in dedicated beds.

<sup>29</sup> Includes provision for under 18 year olds – see page 72-3.

<sup>30</sup> The Working Group notes the evidence that treating people with drug and alcohol problems in these settings is not best practice and, in the case of the Psychiatric Hospitals, will not be an option available in the future as a result of the restructuring of the psychiatric services proposed in Vision for Change.

## Issues

Assessing the volume of residential treatment and rehabilitation services required to meet the needs of problem drug and alcohol users is one aspect of this needs estimation exercise: other issues need to be considered also.

The Four-Tier Level of Care concept, within which these proposals are framed, highlights the need for a standardised assessment protocol as part of the integrated treatment system where the person's first point of contact involves a comprehensive needs assessment. Such a system allows the substance user and the services to systematically identify and address the needs of the client, ensuring that they are referred to the most appropriate treatment modality in the most appropriate setting, providing the highest standards of care and facilitating outcome evaluations.

Where residential treatment is deemed appropriate, evidence suggests that pre-admission preparation (for planned residential treatments) and post-discharge care and support (for all including early self-discharges) are essential elements of a treatment episode, and that their provision needs to be factored into the estimation model in addition to the number of "bed spaces".

The level of service provision would also need to take into account the issue of accessibility in terms of cost, geographic location, cultural/religious diversity, gender, child care and disability (not only in relation to clients but also to their visitors).

## Factors influencing regional provision and recommendations

In the case of regional provision there is a need to balance accessibility to smaller bedded facilities by patients on the one hand against the value of a dedicated unit with a critical mass of beds, staff and expertise on the other hand. While population-based provision was the preferred model of needs assessment, there is also a need to take account of the differing levels of problem opiate use, in particular between the greater Dublin area and elsewhere, when allocating resources. In looking at

regional provision, the working group noted the excellent work of Dr Mai Mannix in relation to the Cork and Kerry region and her recommendations are worth further consideration. Given the variation in regional needs and the distances involved for patients and their families, the question of how the recommended number of regional beds is allocated within each region is a matter for local discussion and planning.

Notwithstanding this, the group recommends that for alcohol detoxification there should be 15 beds for each of the four HSE administrative regions. For illicit drugs there should be 50 IPU beds evenly split between the two regions which contain the greater Dublin area (HSE Dublin Mid-Leinster and HSE Dublin North East) and six beds each for the HSE South and HSE West regions. This proposal is based on the NACD commissioned capture-recapture study of opiate use (Kelly et al 2004) which estimated that there were approximately six times more users in the greater Dublin area than in the rest of the country. This proposed ratio may need to be revised on the basis of the updated capture-recapture Study currently being undertaken.

There is a case to be made in the Irish context for the retention of existing detoxification facilities in local hospitals in rural areas due to the difficulty clients and their families would have in accessing and travelling to a centralised unit given the large geographical areas involved in the HSE Area structures – even though international practice suggests that clients have better outcomes from specialist units.

The working group recommends that, where inpatient units are provided, any stabilisation beds would be physically separated from the detoxification beds.

## Recommended level of under 18s drugs/alcohol provision

Using information to hand from the 2002 Census figures, all available population surveys which interviewed under 18-year-olds about their drug-using behaviour and data from the HSE Child and

Adolescent Psychiatric Service, the working group have estimated the number of rehabilitation beds required for adolescents (aged 12 -17 years) lies between the range of 14 and 37 based on a 28-day stay and an 85% occupancy rate.

### **The Needs of Vulnerable Groups**

Since homelessness is a major criterion indicating client suitability for inpatient treatment, the needs of homeless substance misusers will need to be prioritised.

The group agreed that pregnant women could be accommodated within the expanded (stabilisation) services.

Parents with children present special challenges and the working group wish to highlight and support proposals such as those from Coolmine to expand the use of Ashleigh House on a pilot basis to include an outpatient detoxification phase linked to the existing rehabilitation programme. It is accepted that such a proposal will not meet all of the need for residential services for those with children but it is not possible to quantify the total increase needed at this stage.

The working group note the submission from the Family Support Network outlining the role of the family in the process of recovery of drug users and the recommendation from the UK National Institute for Clinical Excellence (NICE) on the psychosocial management of drug misuse, which recommends that carers and relatives should be involved in decisions about the service users' care and treatment unless the service user specifically wishes to exclude them. In particular, the group draws attention to the recommendations arising from the NACD commissioned report *A Study into the Experiences of Families Seeking Support in Coping with Heroin Use* (Duggan, 2007) and also Action 108 of the National Drugs Strategy regarding the role of families as a resource in facilitating drug users in their recovery. The group values the suggestion from the Family Support Network that one way in which the child-care needs of parents with young children entering residential treatment

could be accommodated is by formally designating families as short-term foster carers.

The working group highlights the need for the treatment services to take on board the general recommendations for the support of families and carers in the 2007 NICE guidelines on both detoxification and psycho-social interventions.

### **Meeting diversity and increasing cultural competence**

The specific needs of substance users with disabilities and those from ethnic minority communities can be met within the increased provision but all service providers will need to provide staff training to ensure an increased level of cultural competence within their service. This can be achieved by including this element within a Quality/Standard of Care Framework as set out in Chapter Six.

### **Step-Down/ Halfway House Accommodation**

The Group recognises that there is a need to increase provision in step-down/halfway house accommodation (from the current provision of 155 beds with a capacity to meet the needs of 368 people, predominantly men) for those leaving residential rehabilitation. Pending detailed discussions with the relevant agencies, the increased capacity for step-down/halfway house accommodation should be a minimum of 30% of residential rehabilitation provision i.e. 296 beds but is likely to be in excess of that, especially given the existing low level of such provision for women (13% of capacity at present) and also to cater for the needs of prisoners and homeless people. The working group recognises the opportunities that are available in working with the Homeless sector in ring-fencing accommodation specifically for former drug users.

Again, the seamless transition from one sub-tier to another is important, in this case from rehabilitation services to step-down/aftercare services, both for the client and to avoid bottlenecks in the system.



## Staffing

The provision of beds has to be accompanied by the provision of an adequate number of trained multidisciplinary staff including access to laboratory services consistent with best practice, as outlined in the SCAN Project report, to ensure full occupancy, maximum safety and the highest standards of care. The working philosophy of the unit will determine the staff mix.

The working group highlights the fact that there is unused capacity within the existing inpatient and residential services due to HSE staff ceilings and recommends that priority should be given to fully resourcing facilities which have been unable to operate to full capacity.

## Need to Review the Provision

Internationally it is recognised that needs assessment models require a number of cycles before they can be fully implemented. Therefore, the match between demand, need and supply can only be addressed adequately over a period of calibration and refining of the original estimates.

The working group recommends that the level of provision set out in this Report be reviewed in March 2010, during which time improvements in data collection would be initiated which would allow more sophisticated projections of needs to be put in place.

## 5.0 Conclusions and Recommendations

5.1 There is a need for more refined data on drug- and alcohol-related problems such as accidents at work, absenteeism and drug-related deaths, in order to allow the use of more sophisticated needs assessment models in future.

5.2 The working group based their estimation of need for inpatient detoxification and stabilisation services on the SCAN Consensus Project (a population-based model); the residential rehabilitation requirement was based on the transition from inpatient and outpatient detoxification to residential treatment; and the numbers of adolescents

requiring treatment was based on population surveys and estimates of problematic substance use.

- 5.3 The working group calculated that:
- Overall, 127 dedicated beds are required in Ireland for medical detoxification and stabilisation, 50% each for drug and alcohol detoxification.
  - In total, 887 residential rehabilitation beds are required, of which between 14 and 37 beds are required for a separate adolescent service(s).
  - These 887 residential rehabilitation beds will address the following needs: 205 for illicit drug users transferring from inpatient detoxification services; 382 for problem alcohol users transferring from inpatient detoxification services; and 300 to address the needs of both drug or alcohol users who have attended outpatient detoxification services.
  - A minimum of 30% of clients attending residential rehabilitation will require step-down/halfway house beds and therefore at least 296 step-down/halfway house beds are required.

- 5.3 The working group calculated that an additional:
- 104 Inpatient Unit beds (for medical detoxification and stabilisation);
  - 252.5 residential rehabilitation beds; and
  - 141 step-down/halfway house beds are required.

- 5.4 In highlighting a deficit of 356.5 beds (104 IPU and 252.5 rehabilitation), the working group notes the estimated 66 beds currently in use for alcohol and drug problems in the psychiatric hospitals and units will no longer be available as a result of the restructuring proposed in *Vision for Change* and the necessity of ensuring that the current resource involved continues to be applied when remedying the deficit in dedicated beds.



- 5.5 The group recommends that 50 inpatient unit beds for illicit drug users should be provided between the Dublin Mid-Leinster and the Dublin North East HSE areas as the available data points to a significantly higher level of need there at present. The remaining 13 IPU beds should be divided between the HSE South and HSE West areas. The group draws attention to the fact that the results from the 2007 Capture-Recapture Study of Opiate Use currently being undertaken for the NACD may require a revision of this recommendation in the future.
- 5.6 In the case of services focusing primarily on the treatment of alcohol problems, the group recommends that they be evenly spread over the four HSE areas since the data suggests a more even distribution of alcohol-related problems throughout the country.
- 5.7 The group's strong preference is that such beds should be provided in fully staffed dedicated units but recognise that problems of patient and family access may militate against this in some parts of the country.
- 5.8 The group recommends as a matter of urgency that, where there is unused capacity at present in a service or unit because of staffing shortages, such capacity be brought on stream immediately by providing the necessary staff.
- 5.9 The staffing of IPUs as well as of residential rehabilitation services must be in line with recognised best practice to ensure full occupancy, maximum client safety and the highest standards of care. Since the treatment approach adopted by a particular service will determine the staff mix required, it is neither possible nor desirable to be prescriptive about numbers or type of staff at this stage.
- 5.10 Arising from the recommendation that transitions from detoxification to residential rehabilitation and then into step-down accommodation be seamless (3.8), the group recommends that an appropriate residential rehabilitation place must be available for each person admitted for inpatient detoxification.
- 5.11 The group recommends that the treatment needs of problem drug and alcohol users who are homeless should be prioritised, since homelessness is one of the key criteria indicating client suitability for inpatient admission.
- 5.12 The increased provision of inpatient unit beds recommended by the group will allow for the stabilisation and respite needs of drug users including pregnant women, cocaine and/or polydrug users. Such stabilisation beds must be physically separated from detoxification beds.
- 5.13 The needs of recovering drug users with young children present particular challenges when it comes to inpatient/residential treatment. The group would welcome the investigation of innovative approaches such as providing the necessary supports so that family members can act as short-term foster parents.
- 5.14 In general, the group were of the opinion that families of drug and alcohol users could be more involved in the overall care plan for recovering users. In particular, the group draws attention to the recommendations in the NACD commissioned report *A Study into the Experiences of Families Seeking Support in Coping with Heroin Use* (Duggan, 2007) and to the specific recommendations on support for families and carers contained in the National Institute for Clinical Excellence's (NICE) guidelines.
- 5.15 The group agreed that the specific needs of substance users with disabilities and from ethnic minority communities can be met within the increased facilities we have recommended, provided that staff training is used to enhance cultural competence within the service. Such training should form part of

the proposed quality assurance framework for Tier 4 services outlined in Chapter Six.

- 5.16 The group recommends that the level of provision set out in this Report should be reviewed in March 2010 and that in the meantime the timeliness and completeness of the data required for more precise projections of need should be improved.

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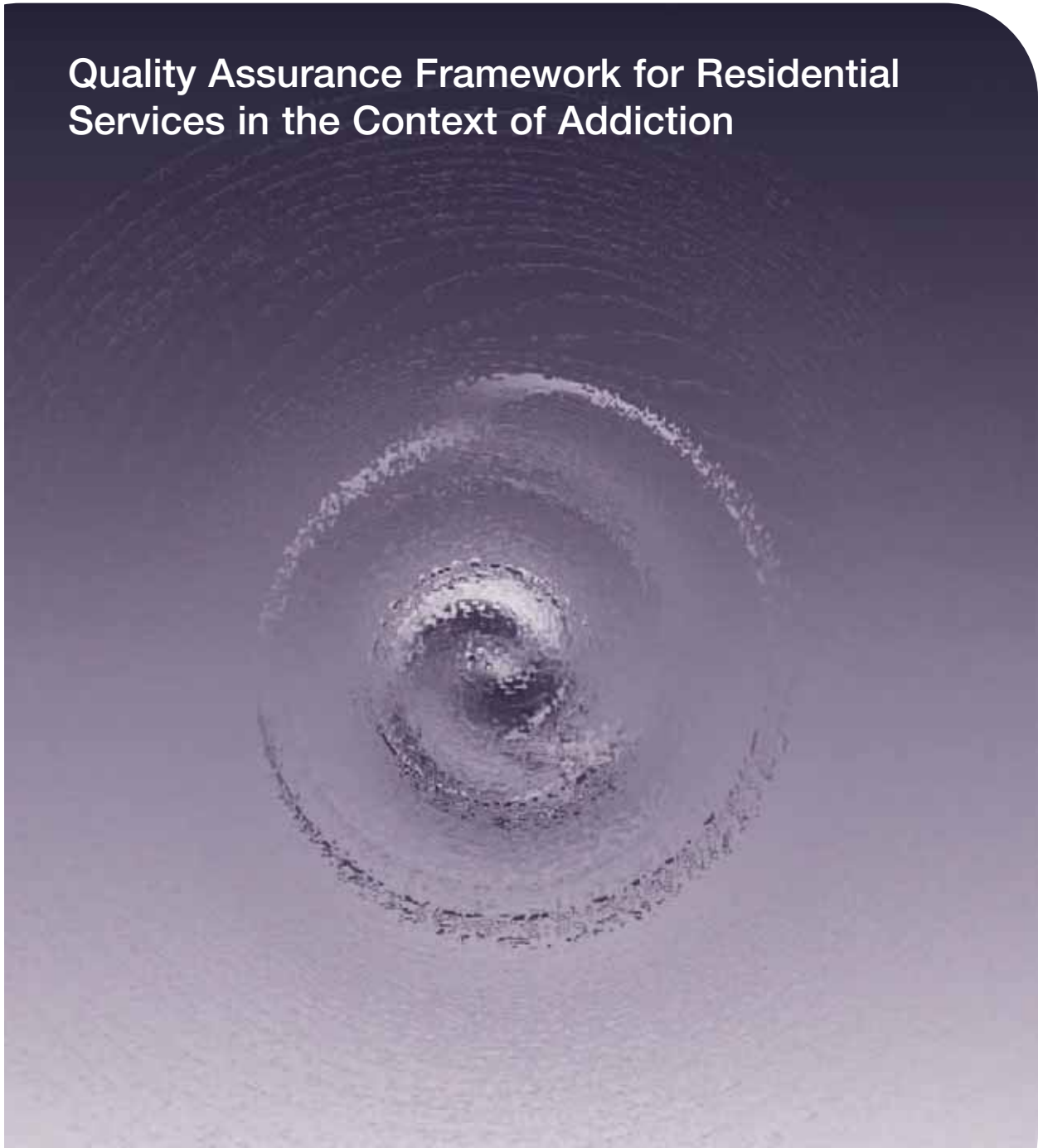
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## Chapter 6

### Quality Assurance Framework for Residential Services in the Context of Addiction



The Terms of Reference given to the Working Group by HSE management require the group:

*to examine current international quality standards/frameworks existing for residential treatment providers operational in other jurisdictions and advise the HSE in terms of what overall standards/quality framework are required for implementation throughout all HSE-funded residential treatment facilities and which will act as a benchmark for all services.*

The working group noted that this request is grounded in Action 50 of the National Drugs Strategy 2001-2008 which requires the HSE (as the successor to the Health Boards) to “develop in consultation with the NACD, criteria to ensure that all State-funded treatment and rehabilitation programmes accord with quality standards”.

### **QuADS and DANOS**

In November 2002, the NACD and the former Health Boards held a seminar (Quality in Addiction Services) which was addressed by representatives of the Irish Society of Quality and Safety in Healthcare, the NDST, ERHA and Alcohol Concern from the UK. This latter presentation dealt with the development of the Quality in Alcohol and Drugs Services (QuADS) suite of organisational standards, developed jointly by Alcohol Concern and Drugscope, and their introduction in the UK. The seminar was informed that the addiction service in one former Area Health Board had used QuADS as a template for developing minimum standards. Five standards were developed using the QuADS approach of Standard Statement and accompanying Criteria: these were Governance, Programmes, Clients, Staffing and Accommodation. The working group noted that occupational standards specifying the standards of performance to which people in the drugs and alcohol field should be working and describing the knowledge and skills workers need in order to perform to the required standard, have now been introduced in the UK as *Drug and Alcohol National Occupational Standards* (DANOS).

DANOS were developed by the Management Standards Consultancy for Skills for Health in 2005. DANOS are seen to be relevant to everyone who is

working to improve the quality of life for individuals and communities by minimising harm associated with substance misuse. DANOS are therefore not just relevant for staff in agencies offering inpatient services but are also relevant to teachers, social workers, GPs, pharmacists, prison officers etc.

DANOS and QuADS are seen to fit together as part of an overall package of quality assurance measures.

Because of their broad application across all four tiers of the drug services, it would be important that such standards should be introduced globally and not piecemeal. It may be that the inpatient sector could be used to pilot a QuADS/DANOS approach perhaps along the lines of the *Audit of Residential Treatment Service* document as developed by the residential treatment sub-committee in the former Northern Area Health Board. However, there is no doubt that quality assurance initiatives for all tiers will require extensive consultation and negotiation followed by intensive training for all staff involved. The working group also noted that such a framework will require extensive resources, not only during the implementation phase but also on a recurrent basis.

The working group recommends the introduction of a suite of measures modelled on the QUADS/DANOS approach as being necessary to ensure that quality services are delivered to clients by a quality-competent staff at all levels of the alcohol and drug services in Ireland.

Because QuADS/DANOS (and the two are interlinked) have been developed by independent UK consultancies, there may be copyright issues surrounding the use of paperwork developed by independent contractors in another country. This is apart altogether from the possible need to adapt the documentation for specifically Irish health/social services which will have a totally different organisational and societal culture to those of the UK services. The group would welcome an effort by HSE management to seek legal advice about the implications of using QuADS/DANOS in this country.

In addition to standards relating to organisational and occupational issues, the working group also recognises that there is a need to consider minimum care standards for the residential facilities which are provided either directly by the HSE or funded by it. The standards for residential care for drug and alcohol users in recovery from addiction cannot be less than those deemed acceptable by society for those for older people, children or people with disabilities. The working group were particularly impressed by the standards set out in the Scottish Executive document *National Care Standards: care homes for people with drug and alcohol misuse problems*. They also noted that in the UK, the Care Standards Act defines a home as a care home if it provides accommodation together with nursing or personal care. Included are homes for persons who are, or who have been, suffering from dependence on alcohol or drugs. Residential services for substance users are required to register under the Act. Inspections are carried out by the Care Standards Commission twice a year with at least one of those visits being unannounced. It is a requirement that all managers and staff of residential homes be appropriately trained and working towards a recognised qualification.

The working group is of the opinion that similar standards should be applied to residential services in Ireland.

### **Monitoring quality standards of care**

The working group has considered the question of the enforcement of these three sets of quality standards i.e. residential, organisational and occupational, subsequent to their introduction by the HSE. The attention of the group was drawn to the work of the interim Health Information and Quality Authority (HIQA) and in particular the plan to incorporate the Social Services Inspectorate (SSI) and the Irish Health Services Accreditation Board (IHSAB) within the statutory HIQA. The SSI was established in 1999 to investigate standards in children's residential centres, foster care services and special care units. The CEO of HIQA is quoted as saying that "the Authority is putting in place

arrangements to establish a robust and rigorous social services inspectorate to regulate the provision of care for older people, for children and for people with disabilities who require residential care"<sup>31</sup>.

The working group recommends that the HSE should consult with HIQA about the inclusion of residential services for drug and alcohol users within the range of services to be regulated by HIQA's social services inspectorate. HIQA should also be consulted about the processes of developing, introducing and monitoring the necessary standards not only in HSE-provided and HSE-funded residential services but in all other residential facilities for substance users.

The working group also recommends that the HSE put in place an internal quality audit function within its Alcohol and Drugs Services regardless of the future statutory role of HIQA in this area, in order to prepare for and respond to HIQA audits of quality of its residential services.

The working group notes that HIQA itself does not plan to encroach or impact on the functions of any "other body established by the Minister to investigate or review on his or her behalf, standards of service or care provided by the Health Service Executive or a person providing a service on its behalf." It is the view of the group that, in the absence of such a body dealing with the quality of alcohol and drugs services in Ireland at this time, unnecessary and costly duplication could be avoided by consultation between the HSE and HIQA.

The working group were particularly concerned that any approach to improving the quality of inpatient and residential services would have a strong emphasis on the following:

- I. That all detoxification procedures meet the highest standards of clinical governance, care and patient safety.
- II. Management and leadership of addiction rehabilitation teams should ensure that staff employed to work in such teams are clear about role definition and

<sup>31</sup> Dr Tracey Cooper, CEO, HIQA in Irish Times of Nov. 17th 2006. Source: [www.ireland.com/newspaper/breaking/2006/1116/breaking25\\_pf.html](http://www.ireland.com/newspaper/breaking/2006/1116/breaking25_pf.html).



purpose, together with assurance of required qualifications and experience. Ongoing training and support for staff is required to assist in role development. Assurance of standards of care will be enhanced by the provision of such a management structure.

- III. Peer reviews, as, for example, that set out in documentation relating to the Quality Network of Therapeutic Communities submitted to the group by Coolmine Therapeutic Community. The group viewed such reviews as a positive element in the development of a quality agenda for such services.

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# Appendix



## Appendix 1: Membership of the HSE Working Group on Residential Treatment & Rehabilitation

<i>Name</i>	<i>Organisation</i>
Dr Des Corrigan (Chair)	School of Pharmacy, Trinity College Dublin.
Dr Aileen O’Gorman (Technical Advisor)	School of Applied Social Studies, University College Dublin
Mr Eddie Arthurs	Drugs Strategy Unit Department of Community, Rural and Gaeltacht Affairs
Prof. Joe Barry	HSE Public Health
Dr Gemma Cox	National Advisory Committee on Drugs (NACD)
Mr Willie Collins	Regional Drug Co-ordinator/ Area Operations Managers Group
Ms Mara de Lacy	Senior Alcohol Addiction Councillor Stanhope Street
Mr Mick Devine	European Association for the Treatment of Addiction
Mr Tony Geoghegan	Voluntary Drug Treatment Network
Ms Sadie Grace/Mr Philip Keegan	Family Support Network
Ms Grainne Hannon	HSE National Hospitals Office
Ms Anna-May Harkin	Department of Health and Children
Ms Linda Hutton	HSE Residential Treatment Services
Dr Jean Long	Alcohol and Drug Research Unit (ADRU) (formerly the Drug Misuse Research Division), Health Research Board
Mr Ruadhri McAuliffe/ Ms Emily Reaper	Union for Improved Service and Education
Mr Brendan Mc Kiernan	HSE Residential Treatment Services

<i>Name</i>	<i>Organisation</i>
Dr Austin O'Carroll	ICGP
Ms Patricia O'Connor	National Drugs Strategy Team
Ms Marion Rackard	HSE Alcohol services
Dr Siobhan Rooney/ Dr Brion Sweeney	Consultant Psychiatrists Group
Mr Jim Ryan	HSE Addiction Services
Mr Vincent Crossan	Secretary to the Working Group
Ms Marie Lowe	Assistant to the Technical Advisor



## Appendix 2: Submissions made to the Working Group

<i>Title of submission</i>	<i>Author/submitted by</i>
Rosie Findings	Submitted by Dr Gemma Cox
Mannix Report	Dr Mai Mannix
List of residential services prepared by NDST	Submitted by Patricia O'Connor
Audit of Residential Treatment	Submitted by Brendan McKiernan
Article "Psychological treatments for alcohol dependents"	Submitted by Marion Rackard
Information on HSE Intercultural Strategy Consultation days	Submitted by Vinny Crossan
Rehabilitation report (draft form)	Submitted by Fidelma Lyons
Community Alcohol Services into the year 2000	Submitted by Mara De Lacy
Alcohol and suicide - submission by Alcohol Action Ireland to the National Strategy for Action Suicide Prevention	Submitted by Mara De Lacy
Letter from Dr Brion Sweeney re Keltoi and Rutland Centre waiting lists	Submitted by Eddie Matthews
Letter informing group on Prisons and Drugs	Submitted by Julian Pugh. Author: Julian Pugh
Submission to the Working Group on Residential Treatment from Statutory Alcohol Services	Submitted by Mara De Lacy
Description of Four-Tiered Model of Care	Submitted by Dr Siobhan Rooney. Author: by Dr Siobhan Rooney
Letter from Peter McVerry Trust	Submitted by Clare Williams
Towards a comprehensive drug treatment in Blanchardstown	Submitted by Philip Keegan. Author: Dave Farrington
The How of Treatment Delivery	Submitted by Marion Rackard
Quality Network of Therapeutic Communities	Paul Conlon
Comments on Residential Rehabilitation from the Family Support	Submitted by Philip Keegan



### Appendix 3: Estimation of Current Capacity of Drug and Alcohol Residential Services, 2007

<b>NATIONAL SUMMARY</b>		
(Population 4,234,925 - Census 2006)		
<b>There are no dedicated residential services in counties Cavan, Laois, Leitrim, Longford, Offaly, Roscommon, Sligo, Tipperary North or Westmeath.</b>		
SERVICE TYPE <sup>32</sup> (N.)	NUMBER OF BEDS <sup>33</sup>	ESTIMATED ANNUAL CAPACITY <sup>34</sup>
<b>Stabilisation Service</b> [Note: these are not stand alone units but beds reserved within the two MD Units]	<b>5.5</b>	<b>87</b>
<b>Community-based Residential Detoxification</b> (2)	<b>15</b> 53% (n=8) alcohol only	<b>170</b> 69% (n=118) alcohol only
<b>Medical Detoxification Unit</b> (2)	<b>17.5</b>	<b>157</b>
<b>Residential Rehabilitation</b> (28)	<b>634.5</b> 31% (n=197) alcohol only 12% (n= 76) men only 0.04% (n=28) women only	<b>3652</b> 36% (n=1310) alcohol only 3% (n=106) men only 1% (n=24) women only
<b>Step-down/Halfway House</b> (14)	<b>155</b> 76% (n=118) men only 10% (n=15) women only	<b>368</b> 78% (n=286) men only 13% (n=47) women only
<b>General and Psychiatric Hospitals</b> (HIPE and NPIRS databases)	79 16% (n=13) Illicit drugs <sup>35</sup> 84% (n=66) alcohol via psychiatric services	3,825 (NPIRS) 718 (HIPE) (2005 data on cases not individuals)

<sup>32</sup> As per Terms of Reference

<sup>33</sup> Some services also treat gambling and eating disorders, however, the number of beds dedicated to these is not set, hence the number of beds and the estimated annual capacity is probably overstated for these service as the estimation assumes all beds are available for drugs or alcohol treatment.

<sup>34</sup> The estimated annual capacity of services, is calculated by dividing the number of days (or weeks or months as appropriate) per year by the duration of programme (using the mean duration if range is given) and multiplying this figure by the number of beds (using the mean number of beds if range is given). 85% of this figure is then calculated to reflect the occupancy rate of services.

<sup>35</sup> This provision may not be additional to that included under Medical Detoxification Units (number 3 above) as one of these services also report throughput to the HIPE database.

## CURRENT RESIDENTIAL SERVICES BY HSE AREA

<b>HSE AREA - DUBLIN MID-LEINSTER</b>		
(Population 1,215,711 – Census 2006)		
Services based in South Dublin, Kildare and Wicklow only.		
<b>There are no dedicated residential services in counties Laois, Longford, Offaly or Westmeath</b>		
SERVICE TYPE (N.)	NUMBER OF BEDS <sup>36</sup>	ESTIMATED ANNUAL CAPACITY <sup>37</sup>
<b>Stabilisation Service</b>	<b>3</b>	<b>55</b>
<b>Community-based Residential Detoxification</b> (0)	<b>NONE</b>	<b>NONE</b>
<b>Medical Detoxification Unit</b> (1)	<b>10</b>	<b>74</b>
<b>Residential Rehabilitation</b> (7)	<b>236</b>  72% (n=177) alcohol only 7% (n=16) men only	<b>1539</b>  76% (n=1822) alcohol only 2% (n=35) men only
<b>Step-down/Halfway House</b> (0)	<b>NONE</b>	<b>NONE</b>

<sup>36</sup> Some services also treat gambling and eating disorders however, the number of beds dedicated to these is not set, hence the number of beds and the estimated annual capacity is probably overstated for these services as the estimation assumes all beds are available for drugs or alcohol treatment.

<sup>37</sup> The estimated annual capacity of services, is calculated by dividing the number of days (or weeks or months as appropriate) per year by the duration of programme (using the mean duration if range is given) and multiplying this figure by the number of beds (using the mean number of beds if range is given). 85% of this figure is then calculated to reflect the occupancy rate of services.

## HSE DUBLIN MID-LEINSTER

(Population 1,214,711 – Census 2006)

Services based in South Dublin and Kildare only.

**There are no dedicated residential services in counties Laois, Longford, Offaly or Westmeath**

NAME OF SERVICE	NO. BEDS	AVERAGE STAY	ESTIMATED ANNUAL CAPACITY	NOTES
<b>STABILISATION SERVICE</b>				
Cuan Dara Cherry Orchard Hospital Dublin	3	17 days	55 <sup>6</sup>	Men and women. Service available for pregnant women.
<b>COMMUNITY-BASED RESIDENTIAL DETOXIFICATION UNIT</b>				
<b>NO SERVICES</b>	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	
<b>MEDICAL DETOXIFICATION UNIT</b>				
Cuan Dara Cherry Orchard Hospital Dublin	10	6 weeks	74 <sup>38</sup>	Men and women. Service available for pregnant women and under 18s.
<b>RESIDENTIAL REHABILITATION</b>				
Rutland Centre Dublin	25	6 weeks	184  [62 – NDTRS 2005]  [210 – 2005, Source: EATA]	Men and women. Drug and Alcohol. Detox needed pre-admission. Also deals with gambling and eating disorders.
St John of God Stillorgan Dublin	12	28 days	133	<b>Alcohol only</b>
Forest Wicklow	12	4 weeks	133	Men and women. Majority alcohol, approx. 40% drugs. Also deals with eating disorders and gambling.
St Patrick's Hospital Dublin	40	3 weeks	589	<b>Alcohol only</b> Also deals with eating disorders.

<sup>38</sup> (Note: Total n. of cases in Cuan Dara = 134 (NDTRS, 2005))

Cuan Mhuire Athy Co. Kildare	125	12 weeks	460  [652 – NDTRS 2005]	<b>Alcohol unit.</b> Men and women. 3 to 4 beds available for drug detoxification for those continuing on into drug rehabilitation programme. Deals with gambling problems also.
	16	20 weeks	35	Drug rehabilitation unit. <b>Men only</b>
Teen Challenge Newbridge Co. Kildare	6	12 months	5	Drug recovery programme. Targets 18+ year-olds
<b>TOTAL</b>	<b>236</b>  72% (n=177) alcohol only 7% (n=16) men only		<b>1539</b>  76% (n=1822) alcohol only 2% (n=35) men only	
<b>STEP-DOWN OR HALFWAY HOUSE</b>				
<b>NO SERVICES</b>	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	

## HSE AREA – DUBLIN NORTH EAST

(Population 926,315 – Census 2006)

Services based in Dublin North, Louth, Meath & Monaghan.

**There are no dedicated residential services in County Cavan**

SERVICE TYPE	NUMBER OF BEDS <sup>39</sup>	ESTIMATED ANNUAL CAPACITY <sup>40</sup>
<b>Stabilisation Service</b>	<b>2.5</b>	<b>32</b>
<b>Community-based Residential Detoxification</b> (2)	53% (n=8) alcohol only	69% (n=118) alcohol only
<b>Medical Detoxification Unit</b> (1)	<b>7.5</b>	<b>83</b>
<b>Residential Rehabilitation</b> (9)	18% (n=20) alcohol only 55% (n=60) men only 15% (n=18) women only	<b>309</b> 43% (n=128) alcohol only 24% (n=71) men only 8% (n= 24) women only
<b>Step-down/Halfway House</b> (7)	<b>87</b> 85% (n=74) men only	<b>201</b> 90% (n=181) men only

<sup>39</sup> Some services also treat gambling and eating disorders – the number of beds dedicated to these is unknown, hence the number of beds and the estimated annual capacity is probably overstated in the case of these service providers as this estimation assumes all beds are available for drugs or alcohol treatment.

<sup>40</sup> The estimated annual capacity of services, is calculated by dividing the number of days (or weeks or months as appropriate) per year by the duration of programme (using the mean duration if range is given) and multiplying this figure by the number of beds (using the mean number of beds if range is given). 85% of this figure is then calculated to reflect the occupancy rate of services.

## HSE AREA – DUBLIN NORTH EAST

(Population 926,315 – Census 2006)

Services based in Dublin North, Louth, Meath & Monaghan

**There are no dedicated residential services in County Cavan**

NAME OF SERVICE	NO. BEDS	AVERAGE STAY	ESTIMATED ANNUAL CAPACITY	NOTES
<b>STABILISATION SERVICE</b>				
St Michael's Ward – Beaumont Hospital	2-3	3-4 weeks	32	Men and Women.
<b>COMMUNITY-BASED RESIDENTIAL DETOX UNIT</b>				
Lantern (Arrupe Society) Dublin	6 (+1 emergency)	4 –8 weeks	52  [31 since March 2006]	Methadone detoxification Clients transfer to residential treatment on completion
Simon Community Detox Dublin	8	21 days	118  [131 – NDTRS 2005]	<b>Alcohol service</b> Homeless men & women.
<b>TOTAL</b>	<b>15</b>  53% alcohol only		<b>170</b>  69% alcohol only	
<b>MEDICAL DETOXIFICATION UNIT</b>				
St Michael's Ward, Beaumont Hospital Dublin	7 – 8	4 weeks	83	
<b>RESIDENTIAL REHABILITATION</b>				
Ashleigh House (Coolmine TC) Clonee Co Meath	8	6 months	14  [17 in first half 2006] <sup>41</sup>	<b>Women only.</b> Aged 18+ Therapeutic community, abstinence based.
Coolmine Lodge Blanchardstown Dublin	30	6-9 month programme	41 <sup>42</sup>  [62 in first half of 2006] <sup>43</sup>	<b>Men only.</b> Aged 18+. Therapeutic community, abstinence based. Many patients connected with Dept of Justice.
Keltoi Dublin	8	8 weeks	44  [38 – NDTRS 2005]	HSE funded service 16+ year olds. Capacity for 20 beds but only 12 available due to staff ceilings. Currently have 8 beds available.

<sup>41</sup> Source: Coolmine 2006:5

<sup>42</sup> Note – Total for Coolmine TC = 149 (NDTRS 2005)

<sup>43</sup> Source: Coolmine 2006:8



Barrymore House Stanhope Centre Grangegorman Dublin	9	4-5 weeks	88	<b>Alcohol only.</b> Men and women. HSE-funded service.  Also deals with gambling problems.
Simon Community Rehab Dublin	11	12 weeks	40 [39 – NDTRS 2005]	<b>Alcohol service</b> <b>Homeless</b> men and women.
Merchants' Quay High Park Dublin	14  (13 + 1 emergency bed)	16 weeks	42  [51 went through programme in 2005]	Men and women. Integrated service which includes 3-week detox. As required. Targets drug users, <b>homeless people and other excluded groups</b>
Victory Outreach Navan Co Meath	10 (Approx)	9 months – 1 year	10	<b>Men only</b> Non medically-assisted detox. Majority <b>homeless and ex-prisoners.</b>
Victory Outreach Drogheda Co Louth	10 (Approx)	9 months – 1 year	10	<b>Women only</b> Non medically-assisted detoxification. Majority <b>homeless and ex-prisoners.</b>
Victory Outreach Slane Co. Meath	10 (Approx)	9 months – 1 year	10	<b>Men only</b> Non medically-assisted detoxification. Majority <b>homeless and ex-prisoners.</b>
<b>TOTAL</b>	<b>120</b> 18% (n=20) alcohol only 55% (n=60) men only 15% (n=18) women only		<b>309</b> 43% (n=128) alcohol only 24% (n=71) men only 8% (n= 24) women only	
<b>STEP-DOWN/HALFWAY HOUSE</b>				
Avoca After Care (Arrupe Society) Dublin	6	6- 12 months	8	<b>Homeless</b> young people. 18+ drug dependent or drug free.
Cuan Mhuire Ballybay Co. Monaghan	12	3 – 6 months	27	<b>Homeless</b> <b>Men only</b>
Coolmine Integration and Aftercare service Dublin	15	6 months	25  [28 in first half of 2006] <sup>44</sup>	<b>Men only</b> (to date) Therapeutic Community Many patients connected with Dept. of Justice.
Teach Mhuire Gardiner St Dublin	25	3-6 months	57	<b>Men only</b> Also deals with gambling addiction and homeless people.

<sup>44</sup> Source: Coolmine 2006:8

George's Hill (Focus Ireland) Smithfield Dublin	7	6 months	12	Men and women.
St James's Camino Network Enfield Co Meath	12	14 weeks	38	<b>Men only</b>
Tabor House Navan Co Meath	10	3 months	34	<b>Men only</b> 18+ year-olds.
<b>TOTAL</b>				
	<b>87</b> 88% (n=74) men only		<b>201</b> 90% (n= 181) men only	

## HSE AREA – SOUTH

(Population 1,080,999 – Census 2006)

Services based in Carlow, Cork, Kerry, Kilkenny, Tipperary South, Waterford & Wexford.

SERVICE TYPE (N.)	NUMBER OF BEDS <sup>45</sup>	ESTIMATED ANNUAL CAPACITY <sup>46</sup>
<b>Stabilisation Service</b>	<b>NONE</b>	<b>NONE</b>
<b>Community-based Residential Detoxification</b> (0)	<b>NONE</b>	<b>NONE</b>
<b>Medical Detoxification Unit</b> (0)	<b>NONE</b>	<b>NONE</b>
<b>Residential Rehabilitation</b> (7)	<b>83</b>	<b>718</b>
<b>Step-down/Halfway House</b> (3)	<b>28</b> 36% (n=10) men only 32% (n=9) women only	<b>85</b> 44% (n=37) men only 39% (n=33) women only

<sup>45</sup> Some services also treat gambling and eating disorders – the number of beds dedicated to these is unknown, hence the number of beds and the estimated annual capacity is probably overstated in the case of these service providers as this estimation assumes all beds are available for drugs or alcohol treatment.

<sup>46</sup> The estimated annual capacity of services, is calculated by dividing the number of days (or weeks or months as appropriate) per year by the duration of programme (using the mean duration if range is given) and multiplying this figure by the number of beds (using the mean number of beds if range is given). 85% of this figure is then calculated to reflect the occupancy rate of services.

## HSE AREA – SOUTH

(Population 1,080,999 – Census 2006)

Services based in Carlow, Kerry, Kilkenny, Tipperary South, Waterford, Wexford.

NAME OF SERVICE	NO. BEDS	AVERAGE STAY	ESTIMATED ANNUAL CAPACITY	NOTES
<b>STABILISATION SERVICE</b>				
NO SERVICES	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	
<b>COMMUNITY-BASED RESIDENTIAL DETOX UNIT</b>				
NO SERVICES	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	
<b>MEDICAL DETOXIFICATION UNIT</b>				
NO SERVICES	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	
<b>RESIDENTIAL REHABILITATION</b>				
Tabor Lodge Belgooly Co Cork	18	28 days	199  [215 = NDTRS 2005; 230 in 2005, source: EATA]	Men and women. Adults and <b>adolescents</b> .  Also deals with gambling and eating disorders
Talbot Grove Castleisland Co Kerry	12	30 days	124  [128 = NDTRS 2005]	Adults and <b>adolescents</b> . Also deals with gambling and eating disorders.
Aislinn Ballyragget Co Kilkenny	12	6 weeks	88  [117 = NDTRS 2005]	<b>Adolescent service 15 – 21-year-olds</b> . Men and women National catchment
Cara Lodge Co Cork	6	12 weeks	22	<b>Boys only aged 14-18</b> Drug and alcohol dependent with co-existing psychosocial problems. Developmental Model/ Therapeutic Community
Aiseiri Wexford	12	28 days	133  [149 = NDTRS 2005]	Men and women 12-step programme. Leinster catchment area. Deals with gambling also.
Aiseiri Cahir Tipperary	12	28 days	133  [157 = NDTRS 2005]	Men and women. 12-step programme.  Primarily deals with alcohol related problems but also deals with gambling and drug problems. Munster/Leinster catchment areas.

MQI – St Francis Farm, Tullow, Co Carlow	11 (10 + 1 emergency bed)	6 months	19 [24 = NDTRS 2005]	Targets drug users, <b>homeless, and other excluded groups.</b>
<b>TOTAL</b>	<b>83</b>		<b>718</b>	
<b>STEP-DOWN OR HALFWAY ACCOMMODATION</b>				
Renewal Women's Service Shanakiel Cork	9	12 weeks	33	<b>Women only</b> , 18+ year-olds. Linked to Tabor Lodge.
Aiseiri/Ceim eile Waterford	9	6 months	15	Men and women
Fellowship House Togher Cork	10	12 weeks	37	<b>Men only</b> Linked to Tabor Lodge.
<b>TOTAL</b>	<b>28</b>		<b>85</b>	
	36% (n=10) men only 32% (n=9) women only		44% (n=37) men only 39% (n=33) women only	

## HSE AREA – WEST

(Population 1,011,900 – Census 2006)

Services based in Clare, Donegal, Galway, Limerick, Mayo.

**There are no dedicated residential services in counties Leitrim,  
Roscommon, Sligo or Tipperary North**

SERVICE TYPE (N.)	NUMBER OF BEDS <sup>47</sup>	ESTIMATED ANNUAL CAPACITY <sup>48</sup>
<b>Stabilisation Service</b>	<b>NONE</b>	<b>NONE</b>
<b>Community-based Residential Detoxification</b> (0)	<b>NONE</b>	<b>NONE</b>
<b>Medical Detoxification Unit</b> (0)	<b>NONE</b>	<b>NONE</b>
<b>Residential Rehabilitation</b> (5)	<b>195.5</b>	<b>1086</b>
<b>Step-down/Halfway House</b> (4)	<b>40</b> 85% (n=34) men only 15% (n=6) women only	<b>82</b> 83% (n=68) men only 17% (n=14) women only

<sup>47</sup> Some services also treat gambling and eating disorders – the number of beds dedicated to these is unknown, hence the number of beds and the estimated annual capacity is probably overstated in the case of these service providers as this estimation assumes all beds are available for drugs or alcohol treatment.

<sup>48</sup> The estimated annual capacity of services is calculated by dividing the number of days (or weeks or months as appropriate) per year by the duration of programme (using the mean duration if range is given) and multiplying this figure by the number of beds (using the mean number of beds if range is given). 85% of this figure is then calculated to reflect the occupancy rate of services.



## HSE AREA – WEST

(Population 1,011,900 – Census 2006)

Services based in Clare, Donegal, Galway, Limerick, Mayo.

**There are no dedicated residential services in counties Leitrim, Roscommon, Sligo, Tipperary North**

NAME OF SERVICE	NO. BEDS	AVERAGE STAY	ESTIMATED ANNUAL CAPACITY	NOTES
<b>STABILISATION SERVICE</b>				
NO SERVICES	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	
<b>COMMUNITY-BASED RESIDENTIAL DETOX UNIT</b>				
NO SERVICES	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	
<b>MEDICAL DETOXIFICATION UNIT</b>				
NO SERVICES	<b>NONE</b>	<b>N/A</b>	<b>NONE</b>	
<b>RESIDENTIAL REHABILITATION</b>				
Cuan Mhuire Bruree Co Limerick	107 <sup>49</sup>  ( 72 alcohol)  ( 35 drugs)	  (8 weeks alcohol)  (13 weeks drugs)	517  (398)  (119)  [Total 799 – NDTRS 2005]	Men and women. Adults and adolescents. Also deals with gambling problems - beds not ring-fenced, numbers treated for gambling vary, often secondary to alcohol.
Bushypark Ennis Co Clare	13	30 days	134  [147 – NDTRS 2005]	Men and women. Also deals with gambling problems.
Cuan Mhuire Athenry Co Galway	50	12 weeks	184	Men and women (ratio 1: 3 – women: men). <b>Adults and adolescents.</b> Also deals with gambling problems.

<sup>49</sup> Estimate based on reported 1/3rd clientele with drug problems.

Hope House Foxford Co Mayo	13/14	30 days	140  [140 in 2005, Source: EATA]	Men and women Also deals with gambling problems. West and North West Connaught catchment area.
Whiteoaks Muff Co Donegal	12	30-37 days	111  [17 – NDTRS 2005]	Donegal/Sligo/Leitrim catchment area.
<b>TOTAL</b>	<b>195</b>		<b>1086</b>	
<b>STEP-DOWN OR HALFWAY ACCOMMODATION</b>				
Cenaloco Mayo	16	At least 6 months	27	<b>Men only</b>
Cuan Mhuire Galway City	12	3-6 months	27	<b>Men only Homeless</b>
Cuan Mhuire Limerick City	6	3-6 months	14	<b>Men only Homeless</b>
Cuan Mhuire Limerick City	6	3-6 months	14	<b>Women only Homeless</b>
<b>TOTAL</b>	<b>40</b> 85% (n=34) men only 15% (n=6) women only		<b>82</b> 83% (n=68) men only 17% (n=14) women only	

## **Appendix 4: Hospitals with a primary discharge diagnosis of alcoholic or drug disorder, or a drug/alcohol principal procedure, who reported to the HIPE and NIPRS databases in 2005**

### **Psychiatric Hospitals**

Carraig Mór, Cork  
Central Mental Hospital, Dublin  
Cluain Mhuire Family Centre, Dublin  
Mental Health Service, Sligo  
Newcastle Hospital, Greystones, Co. Wicklow  
St Brendan's Hospital, Dublin  
St Brigid's Hospital, Ardee, Co. Louth  
St Brigid's Hospital, Ballinasloe, Co. Galway  
St Davnet's Hospital, Monaghan  
St Dymphna's Hospital, Carlow  
St Finan's Hospital, Killarney  
St Ita's Hospital, Portrane, Dublin  
St Joseph's Hospital, Limerick  
St Loman's Hospital, Dublin  
St Loman's Hospital, Mullingar, Co. Westmeath  
St Luke's Hospital, Clonmel, Co. Tipperary  
St Otteran's Hospital, Waterford  
St Senan's Hospital, Enniscorthy  
St Stephen's Hospital, Cork  
St Vincent's Hospital, Fairview, Dublin  
Vergemount Clinic, Clonskeagh, Dublin

### **Private Hospitals**

Hampstead and Highfield Hospitals, Dublin  
St John of God Hospital, Dublin  
St Patrick's Hospital, Dublin

### **General Hospitals with a Psychiatric Unit**

Bantry General Hospital, Co. Cork  
Cavan General Hospital  
Cork University Hospital  
Ennis General Hospital, Co. Clare  
James Connolly Memorial Hospital, Dublin  
Letterkenny General Hospital, Co. Donegal  
Limerick Regional Hospital  
Mater Misericordiae Hospital, Dublin

Mayo General Hospital  
Mercy Hospital, Cork  
Midland Regional Hospital, Portlaoise, Co. Laois  
Naas General Hospital, Co. Kildare  
Our Lady's Hospital, Navan, Co. Meath  
Roscommon County Hospital  
St James' Hospital, Dublin  
St Joseph's Hospital, Clonmel, Co. Tipperary  
St Luke's Hospital, Kilkenny  
St Vincent's Hospital, Elm Park, Dublin  
Tallaght Hospital, Dublin  
Tralee General Hospital, Co. Kerry  
University College Hospital, Galway  
Waterford Regional Hospital

### **General Hospitals**

Beaumont Hospital, Dublin 9  
Cavan General Hospital  
Cork University Hospital  
Ennis General, Co. Clare  
Letterkenny General Hospital, Co Donegal  
Limerick Regional Hospital  
Mater Misericordiae Hospital, Dublin  
Mayo General Hospital  
Mercy Hospital Cork  
Merlin Park Hospital, Galway  
Monaghan General Hospital  
Naas General Hospital, Co. Kildare  
Sligo General Hospital  
St Columcille's Hospital, Loughlinstown, Dublin  
St James' Hospital, Dublin  
St Michael's Hospital, Dun Laoghaire  
St Vincents Hospital, Elm Park, Dublin  
Tralee General Hospital, Co Kerry  
University College Hospital Galway  
Wexford General Hospital

# Glossary

Assisted withdrawal	The process of withdrawing a person from a psychoactive substance by providing medication and psychological support. This allows the process to occur in a relatively comfortable and controlled manner.
Benzodiazepines	The most commonly prescribed minor tranquillisers, known as anxiolytics (for daytime anxiety relief) and hypnotics (to promote sleep).
Buprenorphine	(also known as Suboxone <sup>®</sup> , Subutex <sup>®</sup> , Temgesic <sup>®</sup> ) is a pharmaceutically prepared opioid drug which may be used for the treatment of opioid addiction.
Co-morbidity/Dual diagnosis	The co-occurrence in the same individual of a substance use disorder and another psychiatric disorder.
Dependence	Describes a compulsion to continue taking a drug in order to feel good or to avoid feeling bad. When this is done to avoid physical discomfort or withdrawal, it is known as physical dependence; when it has a psychological aspect (the need for stimulation or pleasure, or to escape reality) then it is known as psychological dependence.
Detoxification (detox)	Describes the way in which a drug, such as heroin, is eliminated from the drug user's body, often with the help of a doctor and/ or specialist drug worker. This is often a gradual process and may take a number of days or weeks. It can involve the use of other drugs such as methadone and buprenorphine and help deal with withdrawal symptoms. However, detox is only the beginning of the process of helping somebody to stay off drugs. Other help such as counselling is usually required.
Dose titration	The process of gradually adjusting the dose of a medication until the desired effect is achieved.
Four-Tier Model of Care	Framework for grouping drug and/or alcohol services into tiers which correspond to the level of need of clients (see Chapter 3, p. 30-31).
Harm Reduction	Focuses on "safer" drug use and aims to reduce the harm that people do to themselves, or other people, from their drug use.
Inpatient Unit	Treatment service which includes detoxification/assisted withdrawal, but also assessment, psychological interventions, harm reduction, relapse prevention and notably stabilisation. Ideally provided with 24-hour cover, seven days per week from a multidisciplinary clinical team under the leadership of a consultant in addiction psychiatry or other medically-qualified substance misuse specialist.
Minnesota Model	Associated with the Alcoholics/Narcotics Anonymous 12-step programme. It sees addiction as a disease, aims for long-term abstinence and includes spiritual as well as practical guidance.
Pharmacotherapy	Treatment with prescribed medication.
Polydrug use	The use of more than one drug, often with the intention of enhancing or countering the effects of another drug. Polydrug use may, however, simply occur because the user's preferred drug is unavailable (or too expensive) at the time

Primary Alcohol User	A person who may use drugs but whose main problem is alcohol abuse or dependence.
Primary Drug User	A person who may use alcohol but whose main problem is drug abuse or dependence
Rehabilitation (rehab)	An umbrella term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol and drugs. The general intent is to enable the patient to cease substance abuse in order to avoid the psychological, legal, social etc consequences of use.
SCAN	The Specialist Clinical Addiction Network is a national network for UK addiction specialists such as consultant psychiatrists, specialist psychiatrists and associate specialists who work in the field of addiction.
Stabilisation	Seeks to ameliorate the impact of chaotic drug use, particularly of cocaine powder, crack cocaine and benzodiazepines, in addition to providing opportunities for dose titration of methadone or buprenorphine in a secure monitored environment.
Substitution programme	Treatment that substitutes a prescribed drug (e.g. methadone) for an illicit drug (e.g. heroin), and in doing so reduces craving and prevents withdrawal symptoms. The removal of the preoccupation with finding and using illicit drugs allows the person to focus on other problem areas in their life and to make use of psychosocial and other treatment interventions.
Therapeutic communities	Operate a hierarchical structure which residents work through based on intense therapy sessions.
Twelve-steps	A set of guiding principles for recovery from addictive, compulsive, or behavioral problems, originally developed by the fellowship of Alcoholics Anonymous (AA) to guide recovery from alcoholism.
Wernicke-Korsakoff syndrome	A form of brain damage associated with alcohol misuse. The symptoms include confusion about time and place, drowsiness, poor balance, double vision, abnormal eye movements and ultimately memory loss. It is treated with larger doses of thiamine (Vitamin B1) by intravenous or intramuscular injection.

