

ANA LIFFEY DRUG PROJECT
POSITION PAPER ON THE
PROVISION OF
LOW THRESHOLD RESIDENTIAL
STABILISATION SERVICES (LTRSS)
IN IRELAND

JUNE 2015

Table of Contents:

Introduction 3
What is a Low Threshold Residential Stabilisation Service (LTRSS)? 3
How does an LTRSS differ from existing services? 3
Why do we need LTRSSs in Ireland?..... 4
How will the service operate? 10
What happens next? 11



Introduction

In December 2014, Ana Liffey Drug Project launched '*Targeting Harm*¹', its strategic plan for the period 2015 - 2017. One of the overarching strategic objectives is "We will innovate to ensure we meet the needs of our Service Users through progressive initiatives". One of the goals under this objective commits the organisation to:

"Secure resources for and pilot Low Threshold Residential Stabilisation Services."

This paper sets out the position of ALDP with regard to Low Threshold Residential Stabilisation Services (LTRSS). Our hope is that it provides an accessible foundation for discussion and engagement with all stakeholders.

What is a Low Threshold Residential Stabilisation Service (LTRSS)?

Simply put, an LTRSS is a service which provides treatment for people with addictions accompanied by complex health and social issues. More specifically, an LTRSS has the following characteristics:

- It is *low threshold* – that is, the barriers to entry are kept as low as possible. So, for example, it is open to all, regardless of current levels or type of drug use
- It is *residential* - it is a medically led inpatient programme, with psychosocial support and follow-up care also provided
- It is focused on *stabilisation* – that is, stabilising the individual's drug use, as well as providing detoxification (if appropriate) and referral to appropriate follow on care in other community or residential settings
- Access to the service is based on individual need, as measured by a comprehensive assessment tool
- It is typically time bound (usually, a stay should be no more than 28 days), but flexible dependant on client need

How does an LTRSS differ from existing services?

The principal difference between an LTRSS and most services that already exist in Ireland is that access to the service is not determined by an individual's drug use; rather, it is based on

¹ http://www.aldp.ie/resources/ALDP_strategic_plan_2015-2017.pdf



a holistic assessment of need. In essence, the aim is to provide a genuinely person-centred service catering to those with greatest need. Thus, service outcomes will not be solely focused on the clinical aspects of addiction, although enhanced stability is an important goal. Similar services to the one proposed are operational in other jurisdictions, such as Scotland² and England³.

There are already a broad range of residential services in Ireland, although none meets the criteria of the proposed service. In 2013, Ana Liffey contacted all such services⁴, with a view to establishing which, if any, had the following characteristics:

- Open access (self-referral)
- Needs based (no restriction on drug use at presentation)
- No cost to client

The reason these characteristics were chosen is that, in our experience, they are the most typical barriers to service access among our client group. No services we contacted offered a service with these three attributes – either there is a gatekeeper referral system, which can act as a *de facto* barrier to service access; or access to the service is dependent on the client having already attained a certain stability in their drug use⁵; or the service is one for which the client is expected to pay. More commonly, it is a combination of these factors.

Why do we need LTRSSs in Ireland?

The need to make available low threshold services for people in crisis has been noted by a variety of policy groups. The ‘Better City for All’ report into antisocial behavior and nuisance in Dublin’s city centre has recommended that:

*“There is a need to make community-based residential crisis stabilization /detoxification unit(s) available. These should target people with problematic poly-substance use (including alcohol) and multiple needs i.e. public injectors, people with mental health issues and people who are homeless.”*⁶

Similarly, the Irish Medical Organisation has called for:

² See, for example <http://www.turningpointscotland.com/what-we-do/substance-misuse/glasgow-drug-crisis-centre/>

³ See, for example <http://www.cranstoun.org/find-help/cranstoun-city-roads.aspx>

⁴ Using the database online at www.drugs.ie as a reference

⁵ Such as not using particular drugs, or only using a specified amount of a certain drug

⁶ Connolly, J (2012) A Better City For All Report, Dublin: Strategic Response Group; page 8



“the establishment of acute alcohol and illicit drugs detoxification centres for those who wish to choose detoxification as part of their recovery”⁷

Similarly, the consultation process for the National Drug Strategy revealed strong public support for additional investment in treatment services:

“There was strong support for further investment in most types of intervention including clinics, counselling, stabilisation programmes and rehabilitation services.”⁸

Participants to the consultations also saw the need to have services that are client centred, with a focus on providing services to meet the needs of clients in a timely manner, rather than a system which demands that clients exhibit certain characteristics before they can access certain types of service. In short, responses should be needs led:

*“The commitment to a continuum of care approach, with a comprehensive service from engagement, through detox and on to aftercare, was a strong theme throughout the consultations. This requires greater coordination and integration of services and the development of formal care plans (including a focus on aftercare) **to place the individual’s needs at the centre of any response. It also implied an approach that would offer both drug - free and harm reduction options**”⁹ (Emphasis added)*

These sentiments were carried through to the framing of the national strategy itself. As an overall strategic aim, the National Drugs Strategy sets out to:

“To provide appropriate and timely substance treatment and rehabilitation services (including harm reduction services) tailored to individual need”¹⁰

Further, Action 34 of the National Drugs Strategy specifically requires the HSE, community and voluntary sectors to support the overall strategic aims by increasing the availability of, and access to, detoxification:

“Expand the availability of, and access to: detox facilities; methadone services; under - 18 services; and needle exchange services where required.”¹¹

⁷ IMO (2015) IMO Position Paper on Addiction and Dependency. Online at [http://www.imo.ie/news-media/publications/Addiction-and-Dependency-IMO-Position-Paper-\(HR2\).pdf](http://www.imo.ie/news-media/publications/Addiction-and-Dependency-IMO-Position-Paper-(HR2).pdf); page 17

⁸ National Drugs Strategy (interim) 2009-2016. Department of Community Rural and Gaeltacht Affairs, 2009. Para 4.97

⁹ National Drugs Strategy; *ibid*

¹⁰ National Drugs Strategy; page 6

¹¹ National Drugs Strategy; page 100



Similarly, the National Drug Rehabilitation Implementation Committee also recognises the need to expand treatment options for drug users. Their framework document notes as follows:

“An adequate level of treatment provision is central to rehabilitation. An expansion of the range of treatment options, including an increase in the number of residential detoxification beds, for recovering drug users is essential. The HSE led Working Group on Residential Treatment/Rehabilitation should consider the issue of treatment provision and make detailed recommendations in this regard.”¹²

In summary, it has been a consistent theme of both local and national policy reports that there is a need for an expansion of residential treatment options. In addition to this, access to these options should be driven primarily by *client need*, not by clinical outcomes or by access criteria set by service providers.

Thus, there is a clear gap in service provision for an LTRSS. There are also strong health-based reasons for providing such a service. The current situation makes it extremely difficult for polydrug users, especially those with chaotic lifestyles to access treatment at an appropriate time. This is problematic, given the strong links between polydrug use and death. It is widely noted that polydrug use is a significant issue in Ireland¹³, but access to many residential programmes are restricted to those using only one drug. For example, of those entering treatment in Ireland in 2010, 54% identified as polydrug users, with the remainder identifying with use of a single substance only. Looking at people presenting with heroin as their primary drug, 62% of those entering treatment in 2010 identified as polydrug users¹⁴. A recent study of attendees at Merchant Quay Ireland’s needle exchange service¹⁵ found that 75% identified as polydrug users. These figures are consistent with European data. In the UK, the National Institute for Clinical Excellence notes that:

“A large proportion of people who misuse drugs are polydrug users and do not limit their use to one particular drug.”¹⁶

¹² Doyle J, Ivanovic J (2010) National Drugs Rehabilitation Framework Document. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive; page 8.

¹³ . It is important to note that while polydrug use could entail, for example, concurrent alcohol and tobacco use , where it is used in this document, it is typically in relation to users for whom heroin, benzodiazepines, z-drugs, and/or cocaine is their primary drug of choice, who are using multiple drugs.

¹⁴ National Documentation Centre on Drug Use - Treatment Data; recovered on 2nd August 2013

¹⁵ See Jennings (2013). Re-establishing Contact: A profile of clients attending the Health Promotion Unit - Needle Exchange at Merchants Quay Ireland. Dublin: MQI

¹⁶ NICE clinical guideline 51. Drug misuse: psychosocial interventions. National Institute for Health and Clinical Excellence, July 2007; p4



And in its 2012 Annual Report, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) notes that:

“Problem drug users are mostly polydrug users, and prevalence figures are much higher in urban areas and among marginalised groups.”¹⁷

Polydrug use is particularly troublesome as it is widely recognised as a factor in drug related deaths. Per the EMCDDA:

“Opioids, mainly heroin or its metabolites, are present in the majority of drug-induced deaths reported in Europe. In the 23 countries providing data in 2009 or 2010, opioids accounted for the large majority of all cases, with 15 countries reporting proportions of 80 % or more, of which six were over 90 %. Substances often found in addition to heroin include alcohol, benzodiazepines, other opioids and, in some countries, cocaine. This suggests that a substantial proportion of all drug-induced fatalities occur in a context of polydrug use.”¹⁸

Thus, it makes sense that in providing flexible treatment options to at risk groups, polydrug users should be a particular target; despite this, polydrug use is a characteristic which will restrict a client’s access to the majority of residential stabilisation or detoxification services currently provided. Of particular concern is that Ireland is currently reported as having the third highest rate of drug related deaths of European countries, and the highest among the EU Member States¹⁹. It is clear from our national policy documents that drug related death is a serious concern; the current National Drug Strategy (NDS) provides for a three pronged approach to tackling drug related deaths, including the implementation of a National Overdose Policy²⁰.

Further, it is incumbent upon us to provide timely, needs based, access to treatment services for drug users. As noted earlier, an overall strategic aim of the NDS is:

“To provide appropriate and timely substance treatment and rehabilitation services (including harm reduction services) tailored to individual need”²¹

¹⁷ European Monitoring Centre for Drugs and Drug Addiction (2012). Annual report 2012: the state of the drugs problem in Europe. Luxembourg: Publications Office of the European Union P. 71

¹⁸ *Ibid*, p.84

¹⁹ See <http://www.emcdda.europa.eu/stats12#display:stats12/drdfig7a> . It does, however, need to be recognised that this analysis may be imperfect as recording standards can vary between countries, and Ireland is typically regarded as having strong reporting tools.

²⁰ See NDS (interim); Action 40

²¹ See NDS (interim); Page 6



Similarly, the Treatment Improvement Protocol (TIP) 45 on detoxification notes the importance of making services available to all patients seeking treatment:

*“2. The detoxification process consists of three essential components, **which should be available to all people seeking treatment:***

- Evaluation*
- Stabilization*
- Fostering patient readiness for and entry into substance abuse treatment”*²²
(Emphasis added)

In the Irish context, it is recognized that it is the client’s presenting need, rather than the potential clinical outcomes around addiction, which should be the primary determinant of service provision. As the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse) notes:

*“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

²² Center for Substance Abuse Treatment (2006). Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 45. Rockville, MD: Substance Abuse and Mental Health Services Administration; page xv



will require and/or is likely to obtain particular benefit from inpatient provision.

These are set out below:

[...]

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.***²³ (Emphasis added)

In the UK, the Specialist Clinical Addiction Network report noted the following about inpatient stabilisation:

“there is considerable evidence that the number of service users with more complex problems (co-existing physical and mental illness, dependence on more than one substance) is increasing. Such cases can be managed in a community setting, but specialist medically managed IPUs²⁴ have potential advantages over less intensive community-based programmes”²⁵

Thus, the proposed service will be targeted at those with needs consistent with those identified above, through a comprehensive assessment process in line with relevant national guidelines. Those whose need is not sufficiently high to warrant immediate inpatient treatment will be referred to other, more suitable, service providers. No waiting list will operate; admission is solely based on need.

²³ Corrigan and O’Gorman (2007). *Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Users)*. HSE; page 27

²⁴ IPU – Inpatient Unit

²⁵ SCAN Consensus Group (2006). *Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service*. Specialist Clinical Addiction Network; page 11



How will the service operate?

Basic Principles

It is proposed to provide a 24 hour, 7 day per week low threshold residential stabilisation programme, at a suitable location. The service will have the following key characteristics:

- *Access will be needs driven.* Admittance will be based on a person's overall presenting need, not just in terms of their drug use, but in terms of their current situation as a whole. No waiting list will operate; when a bed becomes free, it is taken by the person who needs it most, not by the person who is waiting longest.
- *The service will be limited in length.* The goal of the service will be to stabilise people in their drug use, with an option for them to continue to detoxification if they wish and it is medically appropriate. As a preliminary benchmark, maximum stay will be approximately 28 days, although there is flexibility in this in line with good practice and the need to deal appropriately with complex cases of comorbidity, polydrug use, or other factors. Leaving early will not prevent clients from accessing the service in the future, although multiple early departures may affect the way an individual's level of need is assessed; it is also recognised that early departures can be demoralising for the client.
- *There will be no restrictions in respect of drug use.* Clients' drug use will be assessed on entry, and throughout their stay, but no type or level of drug use will act as a barrier to entry. Polydrug users will be admitted, as will people with comorbid mental health issues, where these issues can be safely managed. In all cases, a service will be provided to those with the highest presenting need wherever possible. Where a person's mental or physical health is such that it is a genuine barrier to them receiving the stabilisation service, they will be supported to access an alternative suitable health service.

Service Elements

First presentation

Clients can self-refer, and no prioritisation will be given for any external referral to the service. If a client presents seeking stabilisation, a detailed holistic assessment will be completed using tools which are consistent with appropriate national standards and guidelines. It may take more than one visit to complete the assessment. Assessment will be carried out by a member of the staff team, but not necessarily a nurse. If the client is assessed as having sufficient need to access the service, the assessing staff member will bring the case to a meeting of the staff team on duty, which will include a nurse. The team will decide whether the client should be recommended for admittance, and the prioritisation that should be given to the case. If there is no bed immediately available, the client may be asked to come back on a daily basis until one becomes available. If the client is prioritised and a bed is available, the team will prepare a report for the GP which will set out:



- A brief overview of the client's circumstances
- Details of the assessments carried out to date
- A medical history, insofar as one has been obtained
- A recommended starting medical regime

Admission

Prior to admission, the client will be involved in the development of a structured care plan, setting out clear and attainable goals for the treatment episode. As admission is needs based, some people may be admitted without the opportunity of multiple assessment and planning sessions. For most people, however, it is anticipated that return visits on a regular basis will be required; these sessions will be used for care planning, and for other interventions like BBV testing, and overdose prevention work. No client will be admitted before they have met with the service's GP, who will have a specialist interest in addiction. Once the GP has reviewed the report from the team, they will satisfy themselves that clinical risk has been appropriately assessed, that the medical history is complete and that the starting medical regime as recommended by the team is appropriate, making any adjustments as are necessary in their professional opinion. Once this has occurred, the client will be admitted immediately. Building on the assessment work already completed, a care plan will be put in place, led, insofar as possible, by the client.

During

After initial admission, the client will be monitored every couple of hours around the clock to ensure that they are medically stable. This phase will continue, with adjustments in the client's medication regime as appropriate. The GP will attend at the service every day to get an update from staff and ensure that the medical regimes for each client remain appropriate. The service will also have appropriate GP cover arranged for out of hours periods.

Discharge

Discharge will be managed as part of the client's care plan. Discharge will ordinarily be to a residential treatment facility (where the client wants to do so and has reduced their drug use in line with the particular facility's requirements). However, discharge to day programmes, family, or other structured supports can also be arranged.

What happens next?

The Ana Liffey Drug Project is working to access suitable premises and funding to operate the service on a demonstration basis for a period of three years, commencing in 2017. If you are interested in contributing to this project, please



contact us. We also welcome queries from stakeholders in relation to LTRSS. You can use the details below to contact us.

Ana Liffey Drug Project
48 Middle Abbey Street
Dublin 1
info@aldp.ie

