DRUG TREATMENT POLICIES

A discussion pamphlet on Drug Treatment Policies and including papers presented at a seminar in Trinity College, on April 30,1990.

Ana LifTey Drug Project

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Contents:

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First published by:
Ana Liffey Drug Project in August 1990

BACKGROUND

Drug services cannot and should not be allowed to develop in a policy-making vaccuum. Over the years the Ana Liffey Drug Project has had an important impact on the drug problem. It has engaged in innovative responses, with positive results, and at times when few others dared get in vol ved. It is essential that the lessons of these experiences be channelled into social policy making. Unfortunately, there is no statutory body with responsibility for airing, developing and formulating national drugs policies. There is no mechanism with which voluntary agencies, like the Ana Liffey Drug Project, can be consulted in relation to policy changes and developments. In recent years, in fact, there have been quite dramatic developments in drugs policy, without much, if any, public debate.

The Ana Liffey Drug Project is committed to informing and influencing the drugs policy-making process, through open public debate and dialogue. In April 1990, the Project organised a Public Discussion Forum on Drug Treatment Policies in Trinity College which was attended by over 150 persons from the social, medical and legal services. The guest speaker was Dr. Judy Greenwood, consultantpsychiatrist at the Community Drug Problem Service, Royal Edinburgh Hospital. Dr. Greenwood's contribution focused on the importance of harm minimisation techniques inresponding to problem drug use and HIV in the community. Two speakers responded to Dr. Greenwood-Shane Butler, Director of the Addiction Studies course in Trinity College, and Dr. Fergus O'Kelly, chairperson of the AIDS subcommittee of the Irish College of General Practitioners. Both speakers discussed Dr. Greenwood's contribution in the context of what were very clear similarities between the drugs and HIV situation in Edinburgh and Dublin. The meeting was chaired by Noreen Kearney, lecturer in Social Studies, Trinity College, and a member of the Working Party on Drug Abuse, 1968-1971. The response of the audience at the meeting was very enthusiastic and encouraging and generally the view was that it was a very successful forum. There was also a strong feeling that the seminar papers should be published in the form of a pamphlet.

The Ana Liffey Drug Project has taken on the publication of these papers. Their publication comes at an opportune time, as the Government has reconvened the National Coordinating Committee on Drug Abuse, and requested that it prepare a National Drugs Plan by October 31st next. We have therefore, included in this pamphlet a copy of the Project's submission to the National Coordinating Committee on Drug Abuse. In this pamphlet we have also included a paper on Stockport Community Drugs Team which was kindly prepared for us by two former members of staff, Joe Sheppard and Declan Burke. We sincerely hope that these papers and statements contribute positively to dialogue and discussion on Irish drug treatment policies.

INTRODUCTION TO SEMINAR

Firstly, I wish to thank all of the people who have turned up for this meeting and particularly our speakers who have kindly made themselves available to share some of their experiences in this discussion. All three speakers have considerable experiences to their credit and their contribution to this discussion is to be looked forward to. Secondly, I wish to outline to you the reasons for organising this particular meeting.

Over the years the Ana Liffey Drug Project has maintained the need for a range of care and treatment services for problem drug users. In particular we have highlighted the need for choice in these services and we have pointed out that there is no single solution or treatment for problem drug use. Furthermore, we have advocated the involvement of a wider range of primary, community based, health and social services personnel in providing services to problem drug users.

In recent years there have been many developments in drug services in Dublin which have been influenced by the escalation of HIV infection among injecting drug users. While generally these developments are to be welcomed there is a sense in which they seem to be occurring without much public debate. While there is a certain validity in the argument that too much public discussion delays the implementation of policy it is truer that centralised decisions which take place with inadequate consultation contribute to widespread public suspicion. In the AnaLiffey Drug Project we welcome many of the changes which have been occurring in drug treatment services in recent years. However, we cannot help feeling that if these developments - particularly needle exchange and methadone maintenance programmes - happen without sufficient public debate and consultation, they can all too easily become vulnerable to destabilising influences in the future.

Furthermore, in the Ana Liffey Drug Project, we believe there are other developments in drug treatment services which we would like to see pursued. In particular we would welcome the development of community based models that attempt to involve the primary health and social services in a more integrated response to problem drug use on a local level - i.e. involving the GP, the nurse, the social worker, the community worker, in coordinated intervention and backed up by specialised drug treatment personnel. Currently, there is, regretfully, no plan or proposals, which we are aware of, for the development of services along these lines. Yet, there are, in addition to the many drug treatment services in the city, a considerable number of community care personnel in the frontline of this problem, and many of whom lack backup and support They also lack recognition of the invaluable work which they have been doing over the years and of their unique insights into the problem, its causes and possible solutions.

Many of these people have, at different stages over the years, contacted the project for assistance and we have been only too glad to provide support and advice, albeit at a minimum level. In the lastsix months however, requests for support from community care personnel - some of whom have felt a deep sense of isolation in trying to respond coherently to drug users who have presented to them in a very ill state - have increased considerably. Our capacity to respond in a manner which succeeds in truly coordinating the efforts of community care personnel is extremely limited. Indeed the current level of coordination of the specialised services alone leaves a lot to be desired.

We have therefore, decided to engage directly in public debate on these issues as we would like to hear what others have to say on this subject. This particular meeting this evening is only one aspect of that debate. Over the coming months we will engage in various other activities aimed at focusing discussion on drug treatment policies. In particular, we would like to see more public discussion, and indeed, where appropriate, action on the following:

(i) the setting up of a mechanism, which must include some executive functions, for the coordination of drug treatment services in the Dublin area;

(ii) the setting up of pilot schemes for involving community care personnel (GPs, nurses, social workers, etc) in direct care and treatment of problem drug users, and backed up by specialised drug treatment personnel.

Finally, I sincerely hope that you find tonight's discussion informative. I hope it generates new ideas. Mostly, I hope some informal contacts are made which contribute further to the development of coordinated services

Barry Cullen
DIRECTOR
Ana Liffey Drug Project
April 29,1990.

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Judy Greenwood *is consultant psychiatrist with the Edinburgh Community Drug Problem Service. She previously worked as a general practitioner before moving to community psychiatry. She joined the Community Drug Problem Service when it was set up in 1988*

Background

I will start by listing a whole range of options for working with drug users, ranging from punitive measures, preventive measures and measures aimed at social and political change.

1. Punishment of users
2. Punishment of dealers
3. Increased custom's control
4. Health education (preventive)
5. Community support (voluntary agencies)
6. Needle and syringe exchanges
7. Oral methadone maintenance
8. Out-patient withdrawal regimes
9. Residential detoxification
10. Rehabilitation units
11. Drug treatment in prison
12. Conditional suspended sentencing
13. Voluntary ban on GP prescribing - Temgesic, Temazepam, Diconal
14. Social changes
15. Legalise drugs

Some of the measures are right wing and punitive, some are left wing, and some are liberal and in the middle. I think that in Edinburgh we have had plenty of punishment for long enough and plenty of health education. We have not had many of the responses at the other end of the list. In Britain, we have swung away from the position which existed in the early sixties, a position which was reasonably permissive, and under which we gave methadone to some drug users. This position was reviewed through the seventies and many cities - Edinburgh was one of them - withdrew what medical drug services there were. What remained were the voluntary agencies - in Edinburgh we have four voluntary agencies who offer counselling and support - which clearly had an abstinence orientation and which did an enormous amount of counselling and support Other than the voluntary agencies, Edinburgh had no specialist medical agencies. If drug users wanted referral to psychiatric services they would be treated by a general psychiatrist alongside people with schizophrenia and depression and other disorders. Very few drug users wanted treatment in this manner, and the psychiatric service, because it wasn't specialist, was very underutilised by drug users.

Throughout the eighties, police attitudes also became increasingly hard and there was a great deal of punishment of drug dealers and of people who were found in possession of heroin. A lot of pressure was applied to chemists shops to stop them supplying needles and syringes. So, in fact, needles were in very short supply in the early eighties which was about the time when, unbeknown to all of us, the HIV virus emerged.

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Current situation

Today in Edinburgh, which has a population of half a million, we have between three and four thousand drug users. The exact number is not known but certainly it is in that sort of range. Roy Robertson, who is a general practitioner in Edinburgh, has researched the prevalence rate of HIV in the community in Lothian and compared it to statistices from other regions in the UK.

As you can see from the table, Northwest Thames, which has the highest rate of HTV prevalence in England, actually has half the rate which we have in the Lothian region. For about two years the government were putting out statistics comparing Scotland with England and failing to actually tease out the different regions of Scotland as Robertson has done. When the transmission categories for the UK as a whole and Scotland are looked at, important differences emerge.

Table 1 *HIV Antibody Prevalence 31/3/88*

NW Thames	NE Thames	SE Thames	Oxford	Scotland	Lothian
65.6*	33.9	21.6	11.2	28	113.9

** figures are rates* ***per hundred*** *thousand in the population.*

Table 2 *HIV Infection - UK(n=11218)*
Total by transmission category 30/9/1988

HOMO	*WDM*	***HOIIV***	***BLD***	***HET***	***CHILD***	***OTH***
5390	1678	93	1206	1231	136	2001

Table 3 *HIV Infection - Scotland (n=1504)*
Total by transmission category 30/6/1988

HOMO	***IVDM***	***HO/IV***	***BLD***	***HET***	***CHILD***	***OTH***
233	827	5	85	81	69	203

Table 4 *HTV Infection - Lothian (n= 848)*
Total by transmission category 31/3/88

HOMO	***IVDM***	***HO/IV***	***BLD***	***HET***	***CHILD***	***OTH***
80	496	2	28	56	55	131

These figures, broken down according to transmission categories, are actual numbers of HIV infected people known to be infected who have been tested. It should be underlined that this is just the people who've chosen to be tested. In the United Kingdom as a whole, the main transmission category of the HIV virus are the homosexual population with the intravenous drug misusers constituting a much smaller number. In Lothian, we have a reverse picture of that. The majority of people infected have received their infection through shared needles. There's no question of comparison between a homosexual population who are infected and a heterosexual, drug using group that are infected. This latter group are usually young and mostly unemployed. Many are just starting off in their sexual careers, often with a stable relationship, not necessarily married; often having their first child; and often one of the pair is infected with the virus. This is a very very different scenario to the middle class, middle aged homosexuals in London who've very clearly changed their behaviour dramatically in the last few years. The drug using group are a very risky group not only to themselves but to the rest of the population. Because they are heterosexual and, because many of them are no longer using drugs and likely therefore to have sexual relationships with non drug users, there is a greater likelihood of the problem spreading into the wider community.

Drug users as unpopular people

There is a problem about developing services for drug users, when the assumptions we make about them tend to include the following:

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antisocial
always use illegal drugs
criminal acts
unpleasant habits
infectious
aggressive
unemployed
unskilled
educational dropouts
hidden in housing schemes
emotionally disadvantaged

My assumptions have changed very dramatically now that I've worked for two years with these people. They're all very nice people. They're exactly the same as you and me. The difference is they happen to use one particular drug. They have grown up in an era where illicit drugs were readily available, where to be a bit exploratory and take a few risks and behave in a way that was out of keeping with one's parents age group was acceptable. I think we must be very careful to recognize that this is an epidemic; it is a cultural, behavioural c hange that has happened amongst young people. It isn't just a few weird eccentric people. It is a significant number of the local population in these deprived areas in Edinburgh, and they are all hidden away..;

Because they are engaged in an illegal activity, they do not rally themselves into a consumer lobby of drug users. They are hidden away. There is no public watchdog acting on their behalf. There are very few people who lobby on their behalf apart from the drug agencies. There's nobody out there measuring their unmet health needs. It's very difficult to measure their needs unless the G.P.s put a lot of pressure on the health services, or else the members of Parliament apply pressure, and with a drug using group that's so unpopular you tend to get very little lobbying on their behalf.

Harm reduction approach

Our services started up as one of fifteen centres that the government decided to initiate in 1988 as part of its HIV response programme. I volunteered to provide the necessary medical cover. In that first year of working with drug users, I realised that offering needles and syringes to people who were not prepared to stop injecting was one of a range of options that was relevant. I spelt out and put forth a plan to Lothian Health Board which suggested using a harm reduction approach, particularly for drug users who were not yet at the stage where they're able to contemplate coming off drugs. We've done all the other things for trying to get users off drugs; we've taken away their needles; and we've put them in prison. Frankly, the drug problem was not going away by these approaches and it seemed to me that offering a harm reduction approach, and a needle exchange approach, as well as a treatment approach, needed to be considered.

Our plan is based on a multidisciplinary, community-based, out-patient service, with two separate strategies; one aimed specifically at HIV- and HIV+ drug users; and the other a public education programme.

(a) HIV- and HIV+ drug users

1. Contact
2. Stop sharing/unsafe sex
3. Stop injecting
4. Stabilise oral drugs
5. Reduce crime/prison risk
6. Gradual withdrawal
7. Abstinence

It makes no difference whether a drug user is HIV positive or whether a drug user is HIV negative - fortunately, in relation to harm reduction, the aims are the same. We're needing really to stop both the positives and the negatives either infecting other people or infecting themselves. The positive ones need to be contacted so they don't spread it to other people; and the negati ves need to be contacted because they are the highest risk of becoming positive. The actual management strategy is the same for both. If you don't make contact with people, you can't do anything with them. The word 'low threshold' is being coined to apply to this approach: which is to bring people into services as much as you can, provide crisis support, advice on health care and health education, and to aim to stop people sharing needles and to stop them having unsafe sex and, if appropriate, to stabilise them on oral drugs following a medical assessment. The prevention of injecting is the most critical thing of all. If people are still injecting, they're always running the risk of sharing needles or throwing away needles. While they are still injecting, they are a health risk to themselves or to other people.

Oraltnethadone: Stabilising them on oral drugs is good for a number of reasons; namely, their mental health is much more effective, their relationships are much more appropriate, and it is more possible to work with people if they're on a fixed amount of a drug. If they're all over the place using street drugs - opiates one day, whatever they get a hold of the next day - they've no idea what they're taking and we've no idea what they're taking. If they're stablised on something so that we know what they're using - with conditions attached - then they're much more likely to be workable with, and then, once you've got people stabilised onto a predictable amount of an oral drug, you can start the real work which may take months, or indeed it may take years. You can't do these things overnight because many of them have been drug using ever since they were fifteen. Many don't know what life is like without drugs. It's a very naive middleclass consultant who comes along saying 'I'll give you a detoxification for two weeks and you'll be back to normal'.

Conditions: In our service we do insist that they no longer use street drugs and that they reduce their crime, on the basis that most drug users' criminal behavior is related to getting

their drugs. If we're giving them the drugs by perscription then there's no need for them to be involved in crime. That means they're not going in and out of prison; they're not risking sharing needles in prison which is a very common problem in our prisons. We also insist that they not bother their GP and that they come to see us regularly. If they fail to do any of these things they run the risk of losing their script. It's linking the methadone to saying "Let's treat you as a human being, let's work with you as well as giving you the drug". Clearly, we're coercing them towards gradual reduction, with a great emphasis on the word 'gradual*. They can be picking up their lives, picking up their self esteem, getting their relationships in order, getting a work role going and then, work towards a final goal of abstinence which is a very slow one, and takes a long time to reach for many.

b) Public Education

1. Prevention of drug use
2. Prevention of spread of HIV virus
3. Support of those infected

It's also naive to work simply with the drug users. One has to work with the public as well and prevent new drug users from emerging; preventing people who are not drug users from acquiring the virus, from having unsafe sex; and supporting people who are infected. It's a gTeat responsibility for everybody here to actually see that they're just like the rest of us - it's just unfortunate and unlucky that they happen to acquire this virus when they did - and to treat these people with as much dignity and respect as we can.

Management strategy in community drug problem service

In our service - CDPS - we've got myself as consultant psychiatrist, six psychiatric nurses, two administrators, two part time clinical assistants - one is a psychiatrist and the other is a general practitioner - a psychologist, and we are due to have a social worker and researcher but these haven't come yet. We have sectorised our key workers. When people are referred - usually by letter - we firstly decide which key worker is going to take which referral, depending on where they live. The first appointment is in the community. The person is told that we're going to see them either in a community health centre, or in their own home, or in the social work department, or in their general practitioner's surgery, but somewhere so they don't have to travel too far. After the first assessment, which is usually done by a nurse, we have a management meeting at which we invite as many people as are relevant. If there's a voluntary agency worker we'd certainly invite them; if there's a local social worker involved we'd invite them; I'm usually at that meeting; the nurse is at the meeting and so is the social worker. We all sit around and thrash out what we think is the appropriate management strategy for that particular human being, at that particular moment in time. These really have to be idiosyncratic because each person has their own particular set of problems. We then produce a provisional agreement with contract conditions attached. Usually, we're involved in putting them on methadone for a period of time and this arrangement is kept provisional until we've notified the general practitioner. We then arrange for share-care in the community whereby we're asking the general practitioner to do the prescribing and in exchange for that, our key worker offers regular contact with the client at home, providing counselling and doing regular urine checks. The roles are very similiar to those that we have in schizophrenia, with depression, or any other mental health problem. We, the so called psychiatrical mental health specialist, will offer support - counselling and relationship work - to the person in their own community, and supervise the G.P.'s prescribing. This is exactly what I would do with schizophrenia. When we first put this problem forward the general practitioners had some mixed feelings about prescribing whereupon I said: 'That surprises me. You prescribe for everything else. Why are you making such a different set of assumptions about drug users?".

/'CDPS Management Strategy

(1) CDPS referral
- GP
- social worker
- voluntary agency
- self referral

(2) Allocation of key worker

(3) 1st assessment in community

(4) Management meeting
- key worker
- voluntary agency
- psychia/psycholo/cl. assistant
- social worker
- infect, diseases staff

(5) GP notified + provisional agreement

(6) (a) 3 days methadone at clinic
3 weeks prescription - CDPS
(b) Residential detoxification/rehab.

(7) Shared care in the community
GP - prescribes at recommendation of CDPS, dispensing by local pharmacist
CDPS key worker - sees client regularly at home for family counselling and urine checks, and liaises with GP and voluntary agency

(8) 3 monthly reviews with CDPS team

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We do three month reviews and if necessary we have case conferences at the surgeries and we do meet fairly regularly with the practitioners. There are five hundred and thirty G.P.s in Edinburgh and I can assure you it's hard work. But five hundred and thirty G.P.s sharing the load is far better than me spending my entire week sitting there like a sort of human machine writing scripts and never getting to know these people, never actually doing what appears to be the more important work of counselling them, of building their self esteem, of helping them sort out their relationships.

In the first year we had two hundred and twenty-one referred, of whom half had been tested for HIV. We saw sixty-six per cent in the first year and we saw seventy-six per cent in the second year. As our services develop, more people are n't offered methadone. So that, if you like, is a sort of a vague indication that methadone is only a carrot to get people into the service but it is an adhesive once they're in.

Whether we're actually making any difference is too eary to say. Statistics in America certainly show that people on methadone maintenance programmes have lower HIV seroprevalence and less than those that are not on methadone maintenance programmes. There's more chance they'll go into treatment, there's more chance they'll move towards abstinence if they've been on a controlled methadone programme for a reasonable length of time We've done a mini follow-up and what we have shown is that the needle sharing and the injecting has gone down very dramatically. Relationships have improved. The one very depressing feature

Table 5 - CDPS Statistics for the first *IS* years

	1st Year 88-89	Subsequent 6 months
Referred	221	146
Attended	146 (66%)	111(76%)
Treatment		
Methadone Reduction	68 (47%)	58 (52%)
Methadone Maintenance	38 (26%)	17 (15%)
Detox/Rehab	6 (4%)	
Counselling/Support	34 (23%)	19 (17%)
No Longer Attending	53"(36%)	17(15%)
Lost Contact*	32(21%)	10 (9%)
In Prison	9 (6%)	1
Discharged CP/City	12 (8%)	6 (5%)

* N.B. 25/32 of these from counselling only group)

turning up. In fact, we've now had five hundred and eighty-two referrals. We only started in April '88 but the G.P.s clearly like the service. They are referring more and more people. In the first year, we put about half on methadone reduction and about a quarter on methadone maintenance. In the second year that's changed in that there are more on reduction and fewer on maintenance because we've already got most of the older group of drug users on maintenance, and we're now moving into the younger ones in the second year. Average age is twenty-five Thirty-four we didn't prescribe for, we just offered counselling and support. Of the ones that we lost in the first year which was thirty-six per cent, some we actively discharged, some went to prison, and of the thirty-two we didn' t know what on earth happened to, twenty-five of those we only offer counselling to, we have-

for us and that is that we're distributing a lot of condoms but they are not being used systemaücally and we do have great worries that the heterosexual spread is going to be our third epidemic in Britian. These youngsters are sexually active; they're involved in loving and caring relationships, often monogamous relationships but with one of the pair positive and one of the pair negative and even when they both know that, and even when we give them the condoms, they're still not using them regularly.

Conclusion

In summary, I would say that our methadone programme probably helps a third of the people that we give it to and I think that's no different to using phenothiazine. For those of you who work with mental health problems and schizophre-

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Follow-up

30 on methadone for 6 months
24 (80%) followed up

How feelingi		**Still Injecting?**	
much better	10	most days	2
bit better	8	once/week	1
same	4	occasionally	12
worse	2	never	7
Relationships?		**Still sharing?**	
better	**14**	in last week	2
same	7	in last month	1
worse	**3**	hardly ever	8
		never	13
Condom use?		**Stealing?**	
everytime	4	more	0
sometimes	2	same	1
never	11	less	5
NA	7	**not at all**	18
Weight?		**Finances?**	
gained	8	better	12
same	10	same	9

nia, we tend to give chlorpromazine or what have you to every schizophrenic who comes along; we know a third of them would get better with no treatment, we know a third of them don't get better whatever you do; and it's the middle third that do well on phenothiazenes but we give it to everybody because we don't know which the middle third is. I believe the same thing applies to methadone. I think that a third of the people do extremely well on this; a lot of people now who are off it; a lot of people who are down to minute doses; a third of them carry on mucking around and eventually we put them off the programme. And, a third probably would have done well whatever we'd done with them. But you don't know which third that individual is and so for my book because of HIV and because of the dangers of that, I prefer just to have this fairly blunderbust approach; at worst we'll perhaps have a few people addicted to an opiate substance slightly longer than they would have been but I'd rather pay that price than have a whole lot of them becoming HIV positive and dying away before their time. Thank you.

DRUG TREATMENT: 1965-1990

Shane Butler *is Director of the Addiction Studies Course in Trinity College. He is a former psychiatric social worker with the Eastern Health Board, specialising in alcohol and drug problems*

Introduction

What I want to do is to respond briefly to what Dr. Greenwood has said by presenting you with a quick summary of what's been happening in Ireland leading up to the advent of HIV infection here, in the mid 1980's. One of the difficulties that we had in Ireland was that unlike Britain we had no tradition or history of policy in the drugs field. In Britain there was a long history of policy going back to the mid 1920's and a system whereby any medical practitioner was entitled to prescribe heroin or cocaine. This system remained in operation until the second Brain committee of the late 1960's. Subsequent to that, there was a more conservative approach but there was also a continuing tradition of liberalism . I think that it was to the advantage of the British that they did have this different tradition, that there was some diversity within their system so that when the going got rough in the mid 1980's, it was relatively easier for them to revert to things they had done earlier.

What I've done is I've just looked at the last twenty-five years in Ireland. I'm suggesting that it is only in the last twenty-five years that we have had any perception in Ireland of a drug problem. In fact in 1966, the Commission of Inquiry on Mental Illness concluded that we didn't have a drug problem but that we should be careful. Two years later, the Garda Drug Squad was established which was the first official recognition that we did have some problems associated with the use of recreational illicit drugs. In 1968, we had the Working Party of Drug Abuse which sat from 1968 to 1971. I've divided this 25 year period into three separate phases: 1965-1979; 1979-1985; 1985-1990.

Phase 1 -1965-1979

Mainly what happened in the first fourteen year period was that the services which we created were extremely centralised and they were focused exclusively on total abstinence as a treatment objective which, with the wisdom of hindsight, was a bit unfortunate but at the time of course, it seemed perfectly reasonable. There were two major services established during this period. The first was in 1969 when the National Drug Advisory Treatment Centre was established and in 1973, the other major service we had and to date the only residential rehabilitation centre, Coolemine Therapeutic Community, was established.

It was unfortunate that when we were establishing these services, we didn't take another route, that we didn't look at what was being done for the normalisation of drug problems. We didn't explore the extent to which it would be possible for GPs or mental health services to deal with these problems. From the mid 1960's we have had the development of community psychiatric services. Prior to that of course we had big monolithic Victorian asylums but from the mid 1960's, especially in Dublin, we had the creation of sector services where mental health teams took on responsibility for geographic areas and tried to become familiar with those areas and deliver services close to where people lived.

DRUG TREATMENT: 1965-1990

Unfortunately, during that first fourteen year period the psychiatric services began to dissociate themselves from drug problems. In fact, this was reflected in an administrative way when about 1979, here in the Eastern Health Board area, the responsibility for providing drug services was moved from the Special Hospital Programme - which is the psychiatric service programme - to the Community Care Programmme.

In the early years we were naive, and understandably so. There were quite unreal expectations of what could be achieved by treatment and rehabilitation. People talked about 'get them into treatment'. It was like dealing with chest infection: give them the antibiotics and whether they like it or not, they're going to get better. We began to learn slowly, of course, that drug problems aren't like that.

The major presumption was that all services should be geared towards total abstinence. / There was a genuine confusion between what the role of health and social services was and what the role of the criminal justice system was. It is perfectly legitimate in a democracy for the criminal justice system to enforce prohibition-type policies. However, people who work in health and social services have to be more careful in their understanding of these issues and have to strike a balance without appearing to condone activities that are illegal, but they should still stick to their basic priorities, which is to help people.

Phase 2 -1979-1985

In 1979, we had the beginning of an era which is known as the'opiateepidemic'. Out of the blue there was an enormous increase in drug use, particularly in the use of heroin and this occured in Dublin; and for the first time a major needle culture emerged. The response to this period which went on roughly as I suggested from 1979-85 - it probably peaked slightly earlier around 1983/4 - the response unfortunately was based in the criminal justice system. We had new legislation, a sort of toughening up of our laws. Our politicians took a very hard line when, in 1984, we had the amended Misuse of Drugs Act, where the penalties were all increased and we didn't have any great debate around the issues of treatmentrfehabilitation, and social service provisions. New services were created, or at least new posts were created; it's an exaggeration to call them services. We had the creation of addiction counsellor posts here in the Eastern Health Board. Unfortunately, these were created without any reference to the network of services which already existed within the Community Care Programme. Very often it appeared that no thought had been put into the way in which addiction counsellors were going to liase with all of the other professionals with whom they shared the same team. Many counsellors worked in isolation as a result. The central service which was based in Jervis S treet was retained as the core service, with Coolmine, retaining its position as the only residential rehabilition centre. We were, it appeared ideologically totally committed to abstinence and we were quite unwilling to change.

Phase 3 -1985-1990

Then, unfortunately, out of the blue HIV came along and a scramble occured between 1985 and 1990 during which it became apparent that our ideological commitment to total abstinence was not as secure as we thought it was. This was a period of genuine difficulty for many people who had been working in these services for a long time; the task that they were now being asked to perform was so different. These were people, in good faith, had worked hard for many years with great commitment. They were committed to total abstinence and I think it was really difficult for them to try to adjust to a new system where we were starting to practice what is called 'harm reduction*. That is we were beginning to accept, as it is accepted in other countries, that while our most desirable aim might be to get people to stop using drugs, that we have to go through a period of saying that if we can't get people to stop using drugs, then we have to try to get them to use drugs in a way which is the least harmful way possible.

So, these changes were introduced. Methadone maintenance was introduced in Jervis St. in about '87. It was transferred when the service was transferred over to Trinity Court here in Pearse Street. Needle exchange was created in 1989 and this was notan easy change. Part of the reason was that many of the people who were being asked to take on these new practices were still philosophically and attitudinally committed to total abstinence. It was difficult working in that system to change. It was also difficult because we didn't have any policy statements which made it clearer that we were making a shift. I was searching for some simple illustration of this and the one I picked concerned the end of 1987 when the new centralised drug service in Trinity Court was opened officially by the Minister. In that week at the end of 1987, the *Irish Times* noted that within the space of three or four days, the Minister for Health had indicated very emphatically that he had no time for methadone maintenance, needle exchange, condoms, any of these forms of harm reduction. I can't remember whether it was the day before or the day after the National AIDS Coordinator, Dr. Jimmy Walsh, said that the way forward clearly was through methadone maintenance, needle exchange, and condoms. I am glad that I'm not working in one of those services! This is technically known as an Irish solution to an Irish problem - this ability to look at two directions at one time. It must be extremely uncomfortable for people working in these services because you're not quite sure what will happen if the media picks up on these changes. It's quite controversial and the worker on the ground using new approaches is not sure who gave the mandate for these approaches or whether there is, in fact, a mandate.

Policy Discussion

So, I think what we need is a change right from the top down in terms of policy making. We need some kind of forum whereby we can have discussion. For so long we have assumed that we know what we're doing; we've assumed

that we know what is right; we've assumed that there's no need for discussion. Dr. Greenwood talked about public education and I think that as a public we have not informed ourselves. Dr. Greenwood also said that she was a novice and that there are advantages in being a novice. Novices come without all this ideological baggage. Many of us are not novices and I have to include myself in that. We have over the years built up attitudes and we really do need to rethink them. So what I'll say in conclusion is that it would be useful if we started by basic acceptance of the need for some kind of forum, perhaps a statutory body the equivalent of the Advisory Council on the Misuse of Drugs. We have no body like that in Ireland. We have no Standing Conference on Drug Abuse, we have no Institute for the Study of Drug Dependence. We don't really have any culture of discussion around these issues. Perhaps that is one of the first th ings we could look at. Folio win g that, I think it is very clear that the services need to be normalised. Perhaps with all the resources we have, without spending more money, we could make better use of the resources we have. We have some exceptional GPs like Dr. O'Kelly, who have always worked with drug users, but I think in many instances it has been difficult for GPs to become involved in providing a service for drug users. Our mental health services still aren't involved at all. Perhaps things aren't as bad here as I paint them but I think there is room for improvement. Thank you.

GENERAL PRACTICE EXPERIENCE

Fergus O'Kelly has been a general practitioner (medical) in the south inner city area of Dublin for the last twelve years

I, too, am going to try and respond to Dr. Greenwood's paper. Intravenous heroin use has been a serious problem in Dublin since 1978. Those affected are mainly young people, unemployed with poor educational records. They live mostly in local authority flat complexes in the inner city and suburban local authority housing estates. Ireland's intravenous drug problem is concentrated in Dublin. There's little evidence of the problem outside the city. We estimate that there are about seven thousand people who are known to have used IV drugs over the last ten years. This would fit in with Dr. Greenwood's figures of three to four thousand for Edinburgh, Dublin being roughly twice the size of Edinburgh. However, there has been a decline in the number of new users in the last few years.

General Practice experience

Until recently, the management of drug addiction has centered on a Drugs Advisory and Treatment Center which offers detoxification, maintenance programme and counselling. Now, we have a methadone maintenance service attached to the Eastern Health Board's drop-in centre at Baggot Street - a limited one. G.P.s have largely referred people with addiction problems to these centres but continue to see the patients for problems more usual to general practice. The experience of doctors in general practice is varied. Some try to prescribe for patients with opiate addiction but found that this attracts other users and upsets the practice. Others refuse to see drug users, citing manipulation and threatening behavior as a reason not to do so. Other doctors have a definite policy of non prescription for opiates but are happy to see drug users for any other problems.

Our practice is a two manned general practice attached to the Department of General Practice in the Royal College of Surgeons. It's situated in the south inner city area - an area of high unemployment, high density and low quality housing with poor social conditions. There are large numbers of young people who are mosdy unemployed and as a consequence, there is a high rate of crime. We have extensive experience with the population of drug users since 1979 and have recorded our experiences.

To date, there have been about thirty thousand tests for HIV antibodies that have been carried out nationally. Nine hundred and ten have been found to be sero positive.(January 1990 figures). Sixty per cent of 910 have been infected through intravenous drug use. This is a similar picture to Italy and Spain where 60-65% of AIDS cases occured amongst IV drug users. In The Netherlands, U.K., Denmark, Sweden and Germany over seventy per cent have occured in the homo/bisexual population. It would appear therefore that the more Catholic countries favour IV drug use and the more secular, non-Catholic countries favor sexual transmission of the virus. I'm not sure what this tells us, if anything, about human behavior and religion.

Nearer home, the Dublin experience is closer to that of

Edinburgh. However, even here there are important differences. Of the 3,268 IV drug users tested here, 14.5% are positive. Whereas in Edinburgh, 50% of drug users tested have proven sero-positive. The present Minister of Health, a doctor, a general practitioner, has stated that Ireland's most serious problem with AIDS may result from IV drug users acting as a bridge for the virus into the non drug using population. In the U.S., the Presidential Commission recognises that the future course of the HIV epidemic depends greatly on the effectiveness of our nations ability to address the IV drug abuse problem.

Research of practice records

Our medical practice has been aware of the medical, social and psychological problems presented by intravenous drug users and their families since 1975. We've kept records of these problems and have made special note of patients who're found to be HIV positive, whether tested in this practice or in other clinics. Over the last ten years, we've dealt with 137 people who've admitted intravenous drug use. One hundred and twenty three of these, we felt, were genuinely seeking help. The others attended on one or two occasions and were intent on obtaining prescriptions for opiates only. Of this 137, five have died. Two have died from AIDS and three others who were HIV positive all died by their own hands. This is another point, the figures for AIDS death don't record people who may be just HIV positive and who've died of other reasons. Of the 137 people, 44 are females and 93 males, 27% of the females were sero-positive and 39% of the males were sero-positive. So, out of a group of 137 people 35% are known to be HIV positive. When we carried out this study last year, 54 patients were known to us to be HIV positive. This has now **risen to 67** during that time. Forty-eight of those 54 are intravenous drug users and four are children who were bom to mothers who were drug using. The majority of this group attend the practice regularly and the mean number of visits in the last year was between six and seven, some attending on a weekly basis. Of the 50 adults, 40 are single, six married, four separated but between them they have a total of 48 children who are obviously at risk. Of the 54 HIV positive persons, twenty-nine are related - i.e. they are members of families with two or three affected members. Their families and the community services generally as yet, are ill prepared to meet the consequences of this problem. All these people live locally, have little work experience and the majority have been in trouble with the police for petty crime. This is hardly surprising in an area where unemployment in these flat complexes is as high as 60%. A study carried out in one of these flat complexes five years ago estimated unemployment at this high level. The employmerit situation has deteriorated further since that time. Four of the group of 54 HIV positive patients have developed clinical AIDS. Two have died. There are approximately eight people with symtomatic disease and of the two girls who were pregnant, both IV drug users, have both delivered babies both of whom are HIV positive, one of whom is currently ill.

Practice policy

Our practice experience is probably unique as a general practice in Ireland. However the practice is otherwise a normal one seeing the usual diverse problems normally brought to G.P.s. It is only our location and the willingness to deal with these problems which has led to our experience. Our practice policy for dealing with people unfortunate enough to be caught in the problem of opiate addiction is one of empathy, non-prescription and continuing care and support. After Dr. Greenwood's talk today perhaps we'll have to revise our policy. Anyone attending can expect professional care (I hope), empathy and referral when necessary for specialist care; however, we will not issue prescriptions for controlled drugs under any circumstances to those seeking these. This has been, we hope, appreciated by those we serve. Nationally, only 15% of intravenous drug users have been tested positive for the HIV virus. In our practice, at least 35% of IV drug users are known to be positive. There are many others we know haven't been tested and we believe this to be a gross underestimate.

Social/environmental problem

It is our belief that there are a small number of reasonably well defined areas within Dublin where the rate of HIV infection is much higher than the national figures would suggest. These areas would be the same ones where past research has shown there is a significant drug using population. These areas share many of the characteristics of the area where I practice. It is our belief that the roots of the current drug problem are social and environmental. This view is supported by a recent study on community health priorities issued by the faculty of community medicine. It is our contention that the medical and social problems in these areas are understated and the resources available are inadequate to deal with them. The medical problem of AIDS should not divert attention from these social and environmental problems. IV drug users because of their life style, and the fact that their habit is illegal, are poorly motivated and have few opportunities to organise themselves. This is in contrast to the two other major groups infected with the virus, the homosexual community and the haemophiliacs who are contaminated by infected blood products. Both these latter groups have become organised and it appears have contained or limited their infectivity. It seems that HIV infection continues to rise in the drug using group. Therefore, Irish society may have to recognise that control of HIV spread and stopping of IV drug use are separate problems which require separate strategies.

Future strategies

I 'd like to finish now by alluding to some strategies for future care. I believe that we could target specific catchment areas

and look to these areas where the drug problem exists. Drug users in this city are not a migrant group. They live in their neighborhoods. They live in their homes. They have families and they have networks of support. These areas have economic, social and environmental problems which require political action, not just medical and not just social action. There needs to be an effective coordination between the various agencies, voluntary and statutory, working in this area. There probably needs to be an executive decision maker, who controlling the funds, could make this sometimes disparate group work together, to the one end.

There must be incentives and support for involving primary health and social service personnel. This should be financial if appropriate and it is equally important that their involvement would be resourced and supported at a level which allows planning and development. As an aside, in Scotland the consultation rate for people attending their family doctors is about three to four per annum. Drug users attending doctors in Dundee were found to have a rate of consultation of about seven to eight per annum. HIV positive patients attending a group of doctors, again, in Scotland were found to have a rate much the same.(This is very much in line with figures in our own practice of drug users attending). However, when a practice such as Dr. Roy Robertson's in Muirhouse in Edinburgh offers methadone maintenance, the consultation rate jumps to between twenty and thirty per year. This has huge resource implications for caring for this group.

Under the present capitations scheme, G.P.s are paid eighteen pounds a year to look after males between the ages of sixteen and forty-four. At a consultation rate of twenty to thirty per annum, the idea of a similar practice here is not attractive and would have to be addressed. Dr. Robertson's practice is supported by the Scottish Home and Health Department for reasearch purposes. When I applied for a research grant here I didn't even receive a reply to my application never mind getting it. If we're going to test models for care for general practitioner methadone maintenance, these will have to be piloted. They would have to have all the controls that Dr. Greenwood told us about in Edinburgh. There could also be an extended role for the Addictions Studies course, here in Trinity College, perhaps offering short evening courses to health personnel and to the general public. At the moment, I know there would be health personnel who would like to attend but couldn't do so under the present circumstances. Finally, I'm prepared on behalf of the Irish College of General Practitioners to meet and discuss any strategy to further involve G.P.s in developing their services in the ares of illicit drug use and HIV infection. Thank you for listening to me.

STOCKPORT COMMUNITY DRUGS TEAM

Declan Burke *and* ***Joe Sheppard*** *arefromer staff members of the Ana Liffey Drug Project and are currently employed as part of the Stockport Community Drugs Team*

Introduction

In the following article we will look at the areas of service provision that have been problematic in the development of a comprehensive drug service in the Borough of Stockport. Our main references for service development are the Government's Advisory Committee on the Misuse of Drugs (ACMD) Reports on *Treatment and Rehabilitation* and *AIDS and Drugs Misuse* parts One and Two. These reports give the drug team a firm basis and status with the local authorities who manage the service. Despite this obvious advantage, the development of certain areas of the service have been difficult. Before discussing these areas we will give a description of the structure and work of the drug team.

Stockport Community Drug Team (CDT)

Stockport CDT is a joint initiative between Stockport Social Services and Stockport District Health Authority which services a population of 300,000. The team consits of:-

1 Community Drugs Worker
2 Community Psychiatric Nurse
3 Consultant Psychiatrist - (sessional)
4 Resource/Administration Worker
5 HIV/Drugs Worker
6 Two Half-time Outreach Workers
7 Clinical Assistant - (sessional)

The team was formed to provide a service to Stockport residents who are directly affected by or who are concerned about all types of drug use (excluding alcohol) in the area. The team aims to act as a focus for the treatment of problem drug use but also to explore and implement strategies for prevention and harm reduction. We also offer advice, support and training to other agencies, both statutory and voluntary who are involved with drug users. What we offer falls into four main categories.

1 Harm reduction HIV/AIDS
2 Treatment and rehabilitation
3 Prevention
4 Other areas of work

1 Harm reduction HIV/AIDS

"HIV is a greater threat to public and individual health than drug misuse". (ACMD Report published 1988)

The first goal of our work with intravenous drug users in particular is to prevent them from acquiring or transmitting the HIV virus. For some individuals abstinence will not be acheivable at least in the short term and our eforts focus on the reduction of harm to the drug users themselves. In order to achieve the above we endeavour to provide an attractive and accessible service to users who would not normally come into contact with the agency. Our main methods of achieving this are the following:-

a) Pharmacy exchange schemes

At present seven pharmacists in the areas operate an exchange scheme under the direction of the drugs team. This is a very basic service which offers clean equipment to users, provides basic advice and information and is a drop-off point for used equipment which is then disposed of safely. However, pharmacy schemes are unable to offer more in depth advice and information and so this type of initiative, although valuable as an option to users, is limited in its scope.

b) Outreach work/needle exchange

At present the Team employs two half-time outreach workers. They are employed to operate in the community making contact with drug users not in contact with existing services. They supply clean equipment and condoms to users and give information on harm reduction, safer sex and act as a referral point to the drug team and other appropriate agencies. At present the agency does not have a fixed base needle exchange although equipment is available from the CDT premises. The two outreach workers are looking into the feasibility of setting up a fixed base facility in the near future. One of the major advantages of this method of work is that it gives drug users a forum which allows them to have a critical input in the development of services which cater for their real needs.

c) Clinical assistant:

Many drug users have difficulty in gaining access to primary health care. One of the roles of our clinical assistant is to provide this type of care on a sessional basis in a friendly and non-judgemental environment. We believe that this will attract more users to the service and will provide a comfortable setting in which to undertake work around such issues as safer injecting techniques and HIV/AIDS.

2 Treatment and rehabilitation

It is considered important when dealing with drug users, to be flexible in approach thereby recognising the heterogeneity of users. Treatment programmes therefore are tailored to suit individual needs, recognising both their social as well as medical circumstances. The treatment we offer includes education, co-working with other professions, one-to-one counselling (including HIV/AIDS), family work, detoxification, medical assessment and referrals to other agencies.

Our treatment options consist of the following:

a) Working closely with and supporting GP's who are treating their own drug using clients.
b)The drug team runs a weekly clinic at the local hospital mainly offering methadone detoxification programmes although our aim would be to investigate other treatment options including the use of clonidine and naltrexone. The clinic is for the treatment of clients whose GP is either unwilling to prescribe or feels he/she cannot offer the type of treatment needed.
c) The team has the use of two in-patient beds a the local hospital.
d) the regional Drug Dependence Unit is used as a third tier in our treatment programme e.g. for long term prescribing (maintenance), people injecting their methadone, pregnant users and people needing long in-patient detoxes.

Rehabilitation: On-going one-to-one counselling and family work is offered through the detoxification period and afterwards. Clients are also made aware of self-help groups e.g. Narcotics Anonymous, Families Anonymous, etc. For people who wish to to go to rehabilitation centres we offer a referral system to as wide a range of rehab options as possible.

3 Prevention

We aim to prevent: -

a) Misuse of drugs
b) Harmful use of drugs
c) Media hysteria
d) Parent and family panic
e) Stockport CDT W workload pressure

These aims will hopefully be achieved through education and training. This can be achieved through counselling and liaison work by the use of pamphlets which are easlily accessible to everyone concerned, one-off talks to interested groups, development of an accessible resource centre and finally by means of our existing four day multidisiplinary course which is open to all intrerested workers in the Stockport area and covers a wide range of drug related issues.

4 Other areas of work

We work closely with other agencies particularly probation and social services. We are at present examining our service with regard to the use of tranquillisers and solvents. We work closely with Tranxact, a local voluntary counselling service which works with people experiencing problems with prescribed tranquillisers. We are also building links with local youth workers who come into contact with young solvent users.

The areas that proved to be problematic in the development of the drug service fall under the following headings:-

1 Finance and resources
2 Attitudes to drug use/working with other agencies
3 Working with GP's
4 Harm reduction
5 Training

STOCKPORT COMMUNITY DRUGS TEAM

1 Finance and resources

In line with most areas of the Health Service we are restricted by lack of finance and resources. Although we would wish to offer a totally comprehensive service, in the present climate it is unlikely that we will achieve this. As we are competing against many other services for available monies this places an unhealthy emphasis on numbers of clients seen. Because we see our work as involving much more than just working with clients, as a team we strongly advocate a belief in quality rather than quantity. An important forum for furthering our position is the existence of a District Drugs Advisory Committee. DDACs were set up to advise local authorites on service provision and as members of our team sit on this Committee it gives us an opportunity to highlight drug service needs with senior management

2 Attitudes to drug use/working with other agencies

An important part of our remit is to encourage other agencies/professionals to work with drug using clients. The major problem we encounter is the often negative attitudes towards users found in other professionals. Together with the general air of mystery that surrounds drugs use this often leads to a tendency to dump drug using clients on drug teams when this is an inappropriate response to the presenting problem. To counter this we firstly attempt to encourage professionals to use team members in a consultative manner and offer encouragement and advice to the worker concerned. If this method is not appropriate we then offer to work in conjunction with both the worker and drug user i.e. co-working.

In order to counteract unwillingness and attempt to change attitudes we hold a four day multidisciplinary course every six months which is open to professionals from various agencies. The course consists of a degree of information input but the main emphasis is placed on changing attitudes to drug use and encouraging agencies/professionals tocommit themselves to working with drug users. Our main aims are that participants will go back to their agencies and go some way towards demystifying drug use with their colleagues. The team is committed to breaking down prejudices and to encouraging the view that drug use in all forms is part and parcel of our society.

3 Working with GPs

Following government directives regarding prescribing heroin substitutes, we encourage GPs to undertake the treatment of drug users within their catchment area. We realise that because of G.P. 's other commitments their input with individuals is often limited i.e. they will only be prepared to offer one or two detoxifications per individual. Where detoxification by GPs has proved to be problematic or impossible we have limited facilities at both district and regional level to deal with more difficult cases. Apart from the obvious difficulty when a GP is not prepared to prescribe, our other major area of concern is when GPs prescribe independently and without support and direction from the drug team. As part of our programme of encouraging the active involvement of G.P.'s we are committed to making contact with all G.P. practices in the district (approximately 100) This is a tedious process which often proves to be unfruitful. One way of improving the effectiveness of this approach is by using the new clinical assistant to act as an advocate for the team. We see the clinical assistant as acting as the main liaison person with GPs. One method of achieving this would be the production of a regular newsletter aimed at GPs discussing issues such as prescribing, HIV/AIDS and over-prescribing of tranquillisers.

4 Harm reduction

One area of concern to the team is the prevention of public/media hysteria around the innovative approach to harm reduction. We strongly feel that the provision of injecting equipment, condoms and information about safer drug use/safer sex is the most practical method of reducing the incidence of HIV and other infections among drug users. However, these approaches to harm reduction are stilll in their infancy and are still acause of controversy even among drug workers. Because of possible public concern we have adopted a low key approach to advertising these services. We largely depend on the use of other agencies/professionals and word of mouth to make these services known to the drug using population. As these services become established and are seen to be operating effectively we will then examine the possibility of a more public advertising approach.

5 Training

Because of the changing nature of drug use and particularly the advent of HIV/AIDS we are attempting to place a stronger emphasis on staff training needs. The existence of a Regional Drug Training Unit under the control of the Regional Health Authority makes staff training accessible. Our main problem, however, is the workload pressure on staff and the lack of importance given by management to training which often manifests itself in lack of funding. We are attempting to strike a balance between the needs of the agency and individual staff training needs.

Conclusion

We could finally like to make the point that we believe that no one approach is the answer for every drug user. We attempt to offer a range of options to users including residential rehabs, methadone prescribing, self-help groups, etc. We provide a friendly non-judgemental environment in which users can explore various options and hopefully find their own solutions to their drug use.

POLICY STATEMENT

This statement was submitted to the National Coordinating Committee on Drug Abuse on July 6, 1990

1 INTRODUCTION

1.1 In response to a request from the Minister of S tate at the Departmentof Health to make submissions to the National Coordinating Committee on Drug Abuse, this Policy Statement has been prepared by the Ana Liffey Drug Project and was submitted on July 6th 1990. The policy statement, alongside a number of papers which were presented at a Public Discussion Forum on Drug Treatment Policies held in Trinity College in April 1990, will be published in a pamphlet which will be formally launched in August 1990.

1.2 This policy document pulls together a number of ideas and specific recommendations from the Ana Liffey Drug Project for augmenting and improving drug treatment services in Dublin. In focusing our attentions on proposals for Demand Reduction the Ana Liffey Drug Project has identified seven key issues in drug treatment which need to be addressed. These are as follows:

1. Concentration of illicit drug-use in areas of Dublin
2 Community Priority Areas/Community Drugs Teams
3 Harm Reduction in Drug Treatment
4. The Need for a Full Range of Drug Treatments
5. Lack of Coordination/Consultation
6. Funding of Drug Treatment Services
7. National Forum

The Project has formulated specific proposals in relation to each of these which are outlined in Section 2 and summarised in Section 3 below.

2 KEY ISSUES IN DRUG TREATMENT

Concentration of **illicit** drugs in **Dublin**

2.1 Although services for problem drug users were first established in the late 1960s, it was not until between 1979 and 1983 that Dublin experienced a major increase in the intravenous use of illicit opiatesj(fResearch carried out in the Jervis Street Drug Treatment Centre and by the Medico Social Research Board suggested that such drug use was most marked in areas of Dublin which were already characterised by unemployment, poverty and generalised deprivation. In the intervening years problem drug use in Dublin has stabilised in numerical terms, but there continues to be a significant problem, as confirmed by a recent EC-Pompidou comparative study of drug users attending centres in London and Dublin. It can be stated that Dublin's problem drug users tend:

- to favour opiates, particularly heroin
- to use intravenously
- to be unemployed
- to be early school leavers

12 The illicit drug problem furthermore, is concentrated in a small number of inner city flat complexes and suburban housing estates in the Dublin area - in areas which were refered to as Community Priority Areas in the Ministerial Task Force Report of 1983 - yet, since this particular problem first escalated in the early eighties there has been no successful attempt to devise a separate drug treatment strategy for these particular areas.

23 The Ana Liffey Drug Project recommends that such resources as are available for tackling the demand for illicit drugs should be concentrated, in a coordinated strategy, in those areas in Dublin and its environs which have been most directly affected.

Community Priority Areas/Community Drugs Teams

2.4 **It** is essential that in the *small number* of areas which have been most directly affected by the illicit drug problem a unique strategy is devised which has the capacity to coordinate the various health, social and community service inputs with an individual drug user. This can only happen effectively when overall responsibility for the care and treatment of drug users is devolved to locally based health and social service workers.

2.5 The Ana Liffey Drug Project recommends the setting up of Community Drug Teams (CDT) in those areas of Dublin where, through research or the recorded practice experiences of existing drug agencies and personnel, a high prevalence of problem drug use has previously been identified. These areas, small in number, should be designated Community Priority Areas. They should be geographically defined and located within a single health board community care area

2.6 CDTs should be made up of existing and additional drug treatment personnel who are located in those areas - addiction counsellor, community psychiatric nurse, social worker (either psychiatric or community care) 2-3 local GMS GPs (who have been selected to participate). They should also consist of a practice representative from the Drug Treatment Centre at Trinity Court, Coolemine Therapeutic Community, and Ana Liffey Drug Project (or other voluntary agency if such agency is working in particular area). Other community care, mental health care, Department of Justice or hospital personnel could be invited to CDT meetings as appropriate. CDTs should initially be pulled together by the Director of Community Care in consultation with senior social and medical personnel, the Community Mental Health Teams, and representatives from community and voluntary organisations involved in the provision of drug treatment in the particular catchment area.

2.7 The Ana Liffey Drug Project recommends that the CDT is to take direct responsibility for the management of the drug problem within the Community Priority Area in which it is located. This responsibiltiy should include the operation of the range of programmesdecribed in2.13-2.16below. As these programmes include the provision of medically prescribed methadone their operation cannot happen without medical cover which needs to be provided either directly by the Director of Com m unity Care, the Mental Health Clinical Director or by a GP. The preference is for some form of joint care with the clinical director more involved in intake, planning and coordination and the GP providing ongoing care and treatment. In each Community Priority Area a system would need to be devised for recruiting and remunerating a small number of GPs to participate in the CDT. In relation to non-priority areas the prescribing of methadone should be arranged directly by the clinical director in consultation with GP.

2.8 The CDT should also be a local forum for direct liaison between specialist and non-specialist serv-

ices and in this regard it should endeavour to hold open meetings for all community health and social service personnel on a regular basis.

2.9 Each CDT should conduct an immediate review of drug users in the catchment area. This review should include, for each person, abrief drug history and an assessment of current commitment to and capacity for treatment. When this review is completed a plan for making available to listed drug users the range of treatments outlined in 2.13-2.16 below, should then be drawn up. Thereafter, the role of the CDT is to review and monitor this plan and receive new referrals from the catchment area.

Harm Reduction in Drug Treatment

2.10 The demand and need for a harm reduction approach to drug treatment, particularly in relation to the provision of detoxifications and maintenance programmes, is far greater than can currently be provided with existing drug treatmentservices, and what is currently desirable from a public health point of vie w. The primary reason for this situation is that the core medical service for treating drug users - the Drug Treatment Centre located in Trinity Court - and the main drug rehabilitation service - Coolemine Therapeutic Community - have, since they were founded, based their treatment approaches on an abstinence model of intervention, within which a prior commitment to a drug free lifestyle was expected from problem drug users before treatment was made available. Such abstinence approaches are geared towards providing a specialised service to a minority of drug users, whereas harm reduction approaches are geared towards providing a more generalised service to a greater number of drug users. Since the onset of HIV/ AIDS the need for harm reduction approaches has become clearer and from a public health point of view their proper development is now a priority.

2.11 The Ana Liffey Drug Project recommends an expansion in the provision of harm reduction approaches to drug treatment through involving community based generic and psychiatric personnel in the provision of care and treatment within the community. This generic approach will lead to a

- more normalised service to drug users; it will result in a greater sharing of the workload among health and social service personnel; and it is financially less costly than that of expanding specialised services for the purposes of harm reduction.

The Need for a Full Range of Drug Treatments

2.12 The Ana Liffey Drug Project recommends that the range of treatment programmes in a reorganised service to be offered problem drug users should consist of the following:

1. Basic Harm Reduction
2. Motivational Intervention
3. Methadone Maintenance
4. Drug Free Therapy

2.13 Harm reduction in the form of needle exchange, condoms, advice and information - to be made available on a drop-in basis at a number of designated centres.or clinics.

2.14 Motivational intervention in the form of counselling and methadone stabiliser to be made available through community services (either psychiatric or community care). The methadone stabiliser should be given initially for limited periods and for the purposes of encouraging the drug user to change his/her lifestyle sufficiently to gain entry to a methadone maintenance or drug free programme. In the event of this not happening the methadone stabiliser should then be provided at a central agency, such as the Drug Treatment Centre in Trinity Court or the AIDS Resource Centre in Baggott Street, on an indefinite basis.

2.15 Methadone maintenance to be provided to drug users who demonstrate an interest in coming off illicit drugs but who are not able to do this with a completely drug free lifestyle. Such persons to be provided with methadone maintenance and counselling and group support. The maintenance to be prescribed by participating GPs, or as a temporary measure until such time as a GP has been arranged, by community psychiatric doctors and/or specialist drug treatment doctors at the Drug Treatment Centre, Trinity Court Urine testing to be undertaken at a designated centre or clinic and should be concerned only with illicit or dangerous drugs. Counselling support to be provided through attendance at a designated clinic or centre or through home visits whichever is considered appropriate. If it is necessary to remove a maintenance programme because a person is concurrently engaged in an unacceptable level of illicit drug use (detected through urine testing) or for other reasons (eg failure to participate in counselling, continued involvement in drug-related crime) the person concerned should first be provided with short term stabilising methadone (as in 2.14) for the purposes of renewing previously made commitments or renegotiating new ones. If and when this alternative

approach fails the person should then be offered stabilising methadone at a central agency (as in 2.14 above). Methadone maintenance is by definition long-term and, provided a person fulfils their commitments, it should continue until such time as a person indicates a willingness to cease it, and has been assessed as being suitable, for a drug-free lifestyle.

2.16 Drug free therapy should continue to be provided and it should also be upgraded and resourced in order that it is possible to provide those who are committed to it with a wider range of drug free options. Persons who are assesed as not being sufficiently committed or ready for the rigours of a drug free lifestyle should not be treated with this approach. New drug-free rehabilitation/therapy services should include at least one short-term residential facility, which is not based on a therapeutic community, and a non-residential facility which is based on a full-time work programme. Detoxifications whether from methadone maintenance, methadone stabilising, or illicit drugs should be provided mainly, but not always, through the Drug Treatment Centre in Trinity Court and the therapeutic/counselling support should be provided by whichever is the mostappropriate agency -Drug Treatment Centre, home counselling, centre counselling.TMA, Rutland, Coolemine," Ana Liffey, new services, etc. Medical personnel involved in the provision of detoxification programmes should also be encouraged to explore the feasibility of providing non-opiate detoxifications.

Lack of Structure for Coordination/Consultation

2.17 There is no structure - administrative, professional or otherwise - within which drug treatment services (statutory and voluntary), work in coordination and consultation together, and with other non-specialist agencies and personnel. One important aspect of this lack of structure is that services in the Eastern Health Board area are not firmly located within either the special hospital care or community care programmes. The Community Drug Teams as described above would help to alleviate these problems but in the absence of clear Programme direction, they could also lack administrative authority.

2.18 The Ana Liffey Drug Project recommends that a senior management position of Drugs Coordinator - ideally a person with both practice and administrative experience - be created in the Eastern Health Board. The Drugs Coordinator would have the power and authority to ensure that CDTs were created in each area for which they were identified and that in non-priority areas a basic service is available.

2.19 The Project also recommends that this Drugs Coordinator should be assisted by a team of local coordinators appointed for each Community Priority Area. Local coordinators should be appointed from either existing complement of staff or where this is not possible a new position should be created.

Funding

2.20 Since the illicit drug problem first escalated in the late 1970s there have been serious difficulties in relation to funding the development of an appropriate range of services. One important causal factor in relation to this underfunding has been the restrictions on public expenditure in the areas of health and social services. It is an unfortunate coincidence that both the escalation of the drug problem and pressure on public service expenditure occurred at around the same time. In particular the embargo on staff recruitment to public service employment has meant that many people who work in drug treatment services are employed on temporary, short-term contracts. This naturally has a negative influence on the overall morale and stability of such services.

2.21 While the provision of funds through the National Lottery allocation for AIDS related services since 1988 has improved the financial position of drug treatment services considerably, this in itself has not adequately dealt with the problems of instability and insecurity mentioned above. Nor does this funding mechanism address the need for long term planning of drug treatment services.

2.22 The Ana Liffey Drug Project recommends that a full, separate budget be made available to the Eastern Health Board sufficient for it to ensure the provision of the services and structures recommended above This budget should be made available as a long term exchequer commitment and should not therefore rely on once-off National Lottery allocations. The provision of services by the voluntary/ community sector should be funded by the Eastern Health Board through the mechanism provided in Section 65 of the Health Acts.

National Forum

223 There **is** no ongoing statutory forum for channel-

ling discussion and dialogue on drug treatment policies and within which new developments and changes can be aired, debated and indeed criticised. The absence of such a forum has generated a very high level of suspicion between the voluntary services and statutory agencies. In particular, the dramatic changes which have happened in policy and service developments in recent years, without any real dialogue or consultation, has created a great deal of tension and disquiet among personnel who work in the drugs field. Developments in drugs services should no longer be allowed to happen in this atmosphere and attempts should be made now to ensure that the suspicion which has built up over the last ten years should no longer continue

2.24 The Ana Liffey Drug Project welcomes the government's initiative to consult with the National Coordinating Committee on Drug Abuse (NCCD A) advisory group in relation to preparing its National Drugs Policy for October 1990 and it sees this as a positive attempt to generate open, public dialogue. However, the Project believes that the NCCD A, in formulating its policies, should consult with a wider range of groups than those who are currently represented on the Advisory Group. In particular, the NCCDA should invite submissions from professional health and social service organisations.

2.25 The Ana Liffey Drug Project believes that the NCCDA needs to be constituted as a statutory agency, with an appointed Board to sit for fixed term periods, with executive responsibilities in the areas of research, policy development, public awareness and advising government, and with a budget appropriate to its functions.

POLICY STATEMENT

3 SUMMARY OF RECOMMENDATIONS

3.1. Concentration of Problem

The Ana Liffey Drug Project recommends that such resources as are available for tackling the demand for illicit drugs should be concentrated, in a coordinated strategy, in those areas in Dublin and its environs which have been most directly affected.

32 Community Drugs Teams/Priority Areas

The Ana Liffey Drug Project recommends the setting up of Community Drug Teams (CDT) in those *small number* of areas(Community Priority Areas) of Dublin where, through research or the recorded practice experiences of existing drug agencies and personnel, a high prevalence of problem drug use has previously been identified. The CDT should take direct responsibility for the management of the drug problem within the area in which it is located. It should be made up of existing and additional drug treatment personnel in those areas, who are initially pulled together by the Director of Community Care in consultation with the various social, medical, community and voluntary interests.

33 Harm Reduction

The Ana Liffey Drug Project recommends an expansion in the provision of harm reduction approaches to drug treatment through involving community based generic and psychiatric personnel in the provision of care and treatment within the community.

3.4 Wider Range of Treatments

The Ana Liffey Drug Project recommends that the range of treatment programmes to be offered problem drug users in a reorganised service should consist of the following:

(i) Basic harm reduction in the form of needle exchange, condoms, advice and information, to be made available on a drop-in basis at a number of designated services or clinics.

(ii) Motivational intervention in the form of counselling and methadone stabiliser to be made available to problem drug users through community health services backed up by specialised clinic in either Drug Treatment Centre, Trinity Court or the AIDS Resource Centre, Baggott Street.

(iii) Methadone maintenance to be provided through community health services to problem drug users who demonstrate a commitment to coming off illicit drugs but who are not yet able to do this with a completely drug free lifestyle.

(iv) Drug free therapy to be upgraded and resourced in order that it is possible to provide those who are committed to it with a wider range of drug free options. This range should be expanded to include a short-term rehabilitation facility (non-therapeutic community) and a non-residential, work oriented programme.

3.5 Coordination/Consultation

The Ana Liffey Drug Project recommends that a senior management position of Drug Coordinator be created in the Eastern Health Board area who would ensure Community Drug Teams are created in each Community Priority Areas and that in non-priority areas a basic service is available. The Ana Liffey Drug Project also recommends that the Drugs Coordinator should be assisted by a team of local coordinators for each Community Priority Area.

3.6 Funding

The Ana Liffey Drug Project recommends that a full, separate budget be made available to the Eastern Health Board sufficient for it to ensure the provision of the services and structures recommended in this document This budget should be made available as a long term exchequer commitment and should not therefore rely on once-off National Lottery allocations. The provision of services by the voluntary/community sector should be funded by the Eastern Health Board through the mechanism provided in Section 65 of the Health Acts.

3.7 National Forum

The Ana Liffey Drug Project believes that the National Coordinating Committee on Drug Abuse (NCCDA) needs to be constituted as a statutory agency, with an appointed Board to sit for fixed term periods, with executive responsibilities in the areas of research, policy development, public awareness and advising government, and with a budget appropriate to its functions.