The Introduction of the Opioid Treatment Protocol

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

contents

1. Introduction

This is the first external review of the Methadone Treatment Protocol in Ireland. It seeks to examine the regulatory process and oversight of methadone and opiate dependence treatment, focusing on both the 1998 protocol and the processes by which treatment is implemented and delivered.

The review follows the publication, in September 2009, of the government's National Drugs Strategy 2009-2018. Action 35 in the Strategy requires that a review of the Methadone Treatment Protocol take place to maximise the provision of treatment, to facilitate appropriate progression pathways (including exit from methadone treatment where appropriate) and to encourage engagement with services. The review included engagement with the community and voluntary sectors.

The HSE commissioned Professor Michael Farrell, Professor of Addiction Psychiatry at Kings College London to carry out this review. He was assisted by Professor Joe Barry, Professor of Population Health Medicine at Trinity College Dublin. The administration and project support for this review was provided by Jelena Ivanovic.

The Protocol was reviewed internally by the Methadone Protocol Prescribing Implementation Committee in 2005. The outcomes over time of the recommendations made in the previous review are summarised in Section 4.2.

Background

The problem with illicit drug use became apparent in the mid to late 1960s. A formal response to this was commenced with the establishment of the first clinic in Jervis St Hospital in Dublin in the 1970s. The Government's drug strategy (1991) gave responsibility to the Eastern Health Board for the management of drug treatment services. The Drug Treatment Centre Board (DTCB) at Trinity Court was established following the transfer of the clinic from Jervis St and was separately funded by the Department of Health.

During this time the problem was concentrated in Dublin inner city and some outer suburbs, and there was particular concern around the spread of HIV among injecting drug users. A public health response was fashioned with the establishment in 1991 of a clinic in Baggot St Hospital with the aim of working closely with primary care services. This model was substantially influenced by the model of service provision in Edinburgh, Scotland at the time.

In 1992 further clinics were developed in the north inner city and in the Ballyfermot area. There was subsequent major ongoing demand for methadone maintenance-type services but considerable community resistance to the setting up of such clinics. This resulted in the clinics being restricted to tightly defined catchment areas.

The demand for services exceeded the capacity of these specialist clinics to provide such services and there were long waiting lists for treatment. The Department of Health set up an Expert Group (1993) with the aim of moving stabilised patients out to primary care. This form of treatment was formally initiated following the Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone (1993), which included guidelines for practitioners later to be enforced through the 1998 legislation.

A group was established by the Department of Health and Children in 1997 to assess the use of methadone in the treatment of heroin dependence and in 1998, the *Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations* were introduced. There was a specific administrative structure put in place to monitor treatment delivery through the Central Treatment List (CTL), a database of all patients in receipt of methadone maintenance treatment, and to provide reports on trends in treatment over time. This Protocol was the basis for improving the clinical governance and quality of delivery of drug dependence treatment; it was an innovative and unique approach to promoting the highest professional standards among medical practitioners and allied health professionals.

The heroin problem had primarily been concentrated in the Dublin Metropolitan Area but there was an anticipation of the development of problems beyond the Dublin area. It was viewed that the Methadone Treatment Protocol enabled the development of treatment in places anywhere in Ireland.

Table 1: Prevalence estimates of opiate users aged 15-64 years, by place of residence, 2001 and 2006

Region	Sex / Age Band	Prevalence Estimates		Rate / 1000 population	
		2001	2006	2001	2006
Dublin	Male + Female 15-64	12,456	14,904	15.9	17.6
Rest of Ireland	Male + Female 15-64	2,225	5,886	1.2	2.9
Ireland	Male + Female 15-64	14,681	20,790	5.6	7.2

Table 1 demonstrates the significant growth in prevalence of opiate users outside of Dublin over the period from 2001 to 2006. Cross country comparison data (EMCDDA 2010) on opioid maintenance treatment rates places Ireland above the European average for estimated or reported number of patients in treatment as a proportion of the number of problem opioid users (Figure 1).

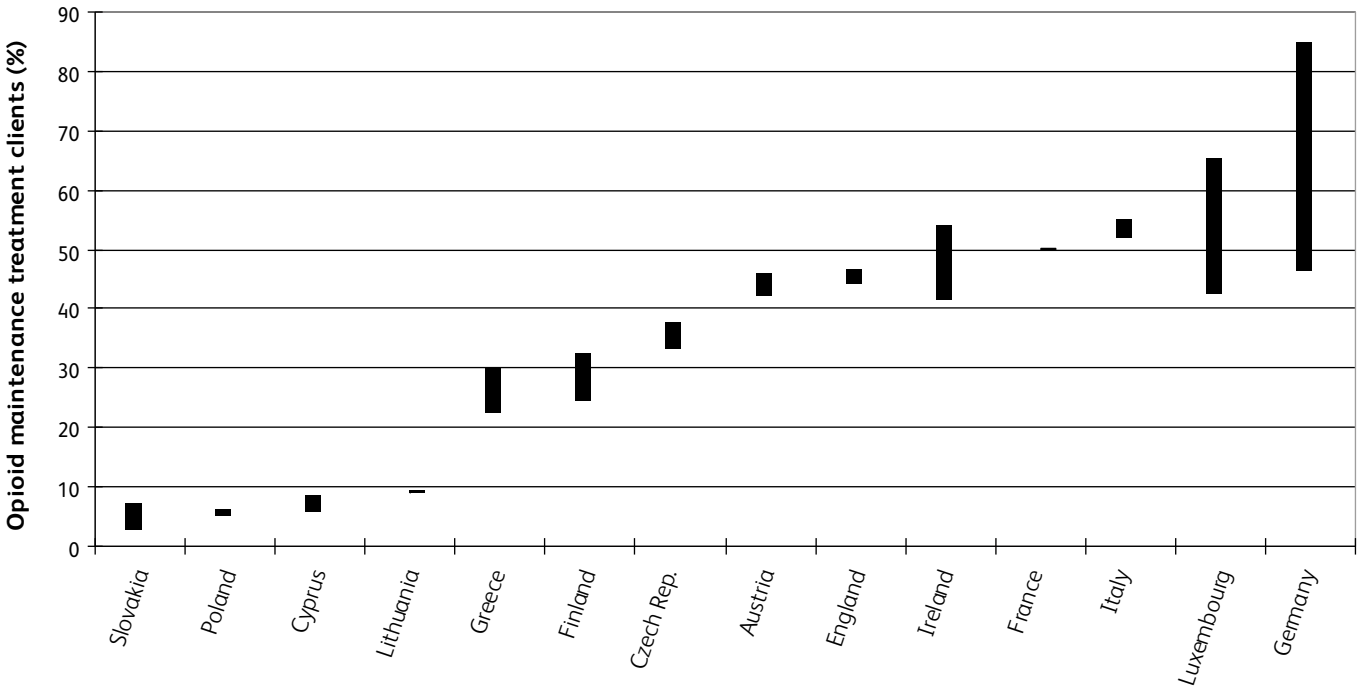


Figure 1: Opioid maintenance treatment clients as a percentage of the estimated number of problem opioid users, EMCDDA data (2008 or most recent year available).

2. Terms of Reference

The HSE, in conjunction with Professors Michael Farrell and Joe Barry, established the terms of reference for the review.

- To review the methadone treatment protocol with regard to maximising provision of treatment including detoxification, stabilisation, and rehabilitation.
- To review the methadone treatment protocol with regard to clinical governance and audit.
- To review the methadone treatment protocol with regard to effectiveness of referral pathways.
- To review the methadone treatment protocol with regard to the enrolment of GPs, the training of GPs, the criteria for Level 1 and Level 2 GPs, and the GP Co-ordinator role.
- To review the methadone treatment protocol with regard to urinalysis testing; its appropriateness and efficacy.
- To engage with the Department of Justice with regard to the prescribing of Methadone in Garda stations.
- To review the methadone treatment protocol with regard to data collection, collation and analysis.

3. Methodology

A notice was drafted to inform all stakeholders about the review process and to invite written submissions from all interested parties.

This notice was advertised in the national press and in specialist medical publications. The notice was publicised via multiple online channels and circulated countrywide to all local media.

For purposes of further and more dynamic engagement with key stakeholders, specific bodies, including representatives from the community and voluntary sectors, were given the opportunity to meet with Professor Farrell to make oral submissions.

The current structure of the Methadone Treatment Protocol and services was reviewed, including updates on current structures, treatment data and previous review recommendations.

A total of 69 written submissions were received from a range of sources (appendix 1). Submissions were analysed and a summary of the themes were aligned with the terms of reference (appendix 2). During July, August and September 2010, 38 oral hearings were conducted with a wide and inclusive range of groups and stakeholders for further in depth discussion and to hear their broader views on the challenges facing drug services and the role of the methadone treatment protocol (appendix 1). The discussions sought in particular to tease out practical and implementable recommendations for change that would assist in the future development of services. The impact of the treatment protocol in practice in a variety of settings was fully explored and discussed. There was a very wide, open, frank and informative discussion on many topics.

On key topics a further brief literature review was undertaken to provide an international context for some of the key recommendations.

Recurrent themes were identified across the submissions and oral hearings, as guided by the terms of reference, and were distilled into recommendations based on an overall pragmatic view on the potential for future implementation.

The *National Drugs Rehabilitation Framework* (2010) was published during the oral hearings and the implications and recommendations from this report were considered as part of an integrated approach to drug service development.

4. Current Provision and Situation

4.1 Treatment Services

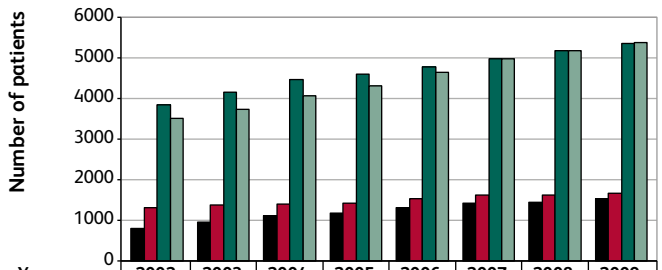
Currently there are three types of settings for methadone treatment: clinics, level 2 and level 1 GPs. All service attendees receiving methadone are registered on the CTL. At the end of December 2009 there were 8,551 patients (of which 5,352 were in clinics) receiving methadone treatment across these services, compared with 5,965 (of which 3,849 were in clinics) at the end of December 2002 (Figure 2). The data as currently collated does not include prisons, in the future it would be useful for have prisoners included.

Clinics are a mix of larger addiction centres and satellite clinics. There are a small number of the larger style clinics that were established in the 1990s, and a greater number of satellite clinics with smaller case loads. The medical work force is a mixture of clinic doctors, some with general practitioner training, and input from consultant psychiatrists. The Department of Health and Children's policy document on mental health *A Vision for Change* presents a challenge for drug services. The lack of focus on addictions as a key public mental health burden has the potential to limit future combined strategic developments in both areas

The DTCB has been, to date, an independently managed statutory service provider but the Government has recently decided to subsume it into the HSE and its future potential role is under review.

The Methadone Treatment Services Review Group recommended and endorsed the scheme of GP involvement in methadone prescribing outlined in the Irish College of General Practitioners' report. Under the scheme, GPs are contracted to provide treatment on the basis of one of two levels – level 1 or level 2. At the end of December 2009 there were 1,525 patients with level 1 GPs compared to 807 in 2002 (Figure 2). There were 1,674 patients with level 2 GPs in 2009 compared to in 1,309 in 2002. The number of level 1 GPs has grown from 151 in 2002 to 218 in 2009 (Figure 3).

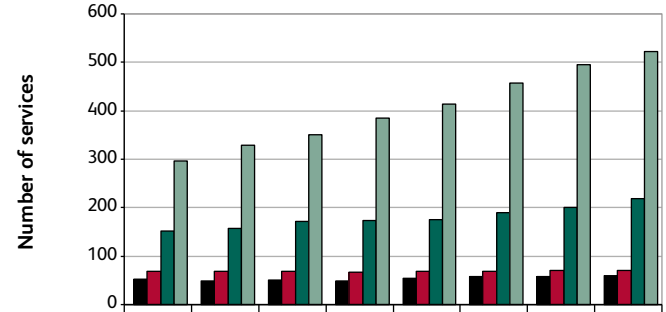
There were less than 5 % of the patients in level 2 practice transferred to level 1 GPs annually over the period 2002 to 2009 (Table 2).



Year	2002	2003	2004	2005	2006	2007	2008	2009
GPs L1	807	945	1112	1172	1316	1422	1444	1525
GPs L2	1309	1369	1389	1423	1526	1624	1620	1674
Clinics	3849	4157	4456	4598	4768	4979	5181	5352
Pharmacies*	3508	3727	4063	4301	4650	4976	5183	5382

Figure 2: Number of patients attending clinics, level 1 and 2 GPs, and pharmacies, CTL data 2002 – 2009.

* All patients with GPs and some patients in clinics attend pharmacies for methadone dispensing.



Year	2002	2003	2004	2005	2006	2007	2008	2009
GPs L2	53	48	50	49	54	58	58	59
Clinics	68	68	68	67	69	69	71	70
GPs L1	151	157	171	174	175	189	201	218
Pharmacies	296	329	350	385	414	458	496	522

Figure 3: The number of clinics, level 1 and 2 GPs and pharmacies providing methadone treatment, CTL data 2002 – 2009.

Table 2: Proportion of patients transferred from clinics and level 2 GPs to level 1 GPs, CTL data 2002 – 2009.

	2002	2003	2004	2005	2006	2007	2008	2009
Total number of patients with GP L2 and clinics	5,158	5,526	5,845	6,021	6,294	6,603	6,801	7,026
Total number of transfers to GP L1 from clinic and GP L2	272	170	275	238	253	239	270	311
(% transfers to level 1)	5.01	2.98	4.49	3.80	3.86	3.49	3.82	4.24

Level 1 GPs

- Level 1 GPs treat stabilised opiate dependent persons who have been referred from HSE drug treatment centres or from Level 2 GPs.
- To practice as a Level 1 GP s/he must complete a recognised training programme co-ordinated by the Irish College of General Practitioners and agree to regular educational updates.
- The GP is audited by the Irish College of General Practitioners/HSE Audit Committee.
- The person attending the GP is registered on the CTL and is issued with a treatment card, which is kept by a specified pharmacist.
- A Level 1 GP can treat up to a maximum of 15 patients.
- The GP receives no fees from the patient or any other source except from the HSE for this service.
- The GP can only issue a prescription for a supply for a period of not greater than seven days.
- The prescriptions for methadone are subject to control under the *Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998*.

Level 2 GPs

- This is a GP who has undergone more training than a Level 1 GP and who is more experienced in working with opiate dependent persons. These GPs can initiate treatment of opiate dependent persons.
- The GP is audited by the Irish College of General Practitioners/HSE Audit Committee.
- The Level 2 GPs have undergone a more advanced training programme agreed between the Irish College of General Practitioners and the HSE.
- The GP can treat up to maximum of 35 patients or a maximum of 50 in a partnership with 2 or more doctors in their own practice.

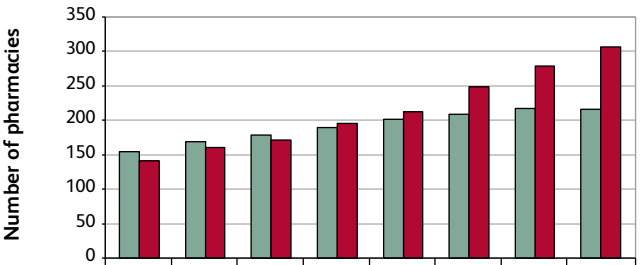
Pharmacy Service

The involvement of the community pharmacists in the dispensing of methadone allows for a large number of opiate dependent persons to be treated in their own local area, as recommended by the Methadone Treatment Services Review Group.

This service has continued to expand over the past decade. The Pharmacy service is a critical component of the overall delivery of the Protocol.

In December 2009 there were 522 community pharmacists involved in the Protocol compared with 293 in December 2002 (Figure 3). There is a growing number being trained and delivering services outside the Dublin area (Figure 4). The partnership between the clinical services and the pharmacists appears to be working well.

A strategic document was developed to expand the role of pharmacists to include needle exchange and there is an evident need for this. The roll out of needle exchange through community based pharmacy outside of Dublin has been progressed through to the planning stage and it is envisaged roll out will commence in 2011.



Year	2002	2003	2004	2005	2006	2007	2008	2009
Dublin	155	169	179	190	202	209	217	216
Rest of Ireland	141	160	171	195	212	249	279	306

Figure 4: Number of pharmacies in the methadone treatment protocol, CTL data 2002-2009.

Service Development Nationally

Regrettably the drug problem has not been confined to the East Coast and is apparent in small and large communities in many parts of the country now. This includes cannabis, ecstasy and stimulants but also heroin and injecting heroin use. In addition, the Government decided in 2009 to incorporate alcohol into Ireland's new substance misuse strategy. This will require a re-focussing to non-pharmaceutical responses and will also challenge the existing services in terms of capacity to respond. There is a need for comprehensive coverage of services in order to meet the growing demand (Figure 5). There are a significant number of young heroin users in prison who have no access to community based drug treatment services in some parts of the country, mainly outside Dublin. Services have developed in Athlone, Galway, Limerick, Cork, Waterford, Carlow and Portlaoise with small teams delivering a methadone prescribing service. Some of these require support from non-local level 2 doctors but it is desirable that a more permanent local medical input is organised in the near future for the purposes of continuity of service delivery. There are plans to expand the specialist input to these services and it is recommended that the two regional specialist posts as consultant addiction psychiatrists for the West and South West be appointed urgently.

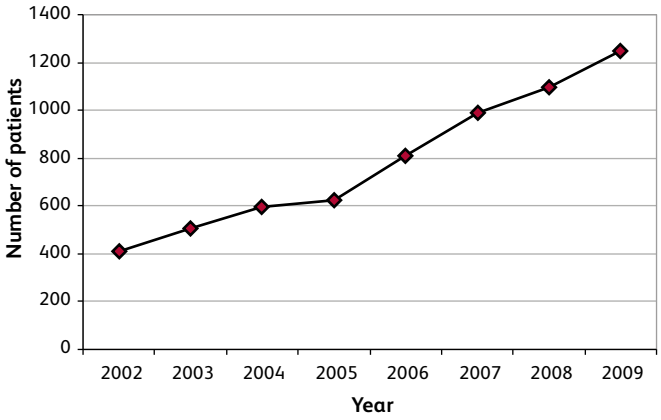


Figure 5: Number of methadone patients seen outside of Dublin, CTL data 2002-2009.

Drug Related Deaths

Drug related death is one of the most devastating negative consequences for families, communities and individuals, and is particularly related to injecting drug use and polydrug use. Those who are out of treatment are approximately three times more likely to die than those who are stable in treatment. The early period in treatment and the period on leaving after detoxification are associated with an increased risk of death.

Interpreting trends in death rates is difficult in the absence of robust data on the numbers at risk at any given time. The overall trend in Europe has been downward since 2000 (Figure 6). The mean age of those dying has been climbing in a number of European countries (EMCDDA 2010) and in Ireland this has risen from 29.9 years in 1998 to 32.1 years in 2007.

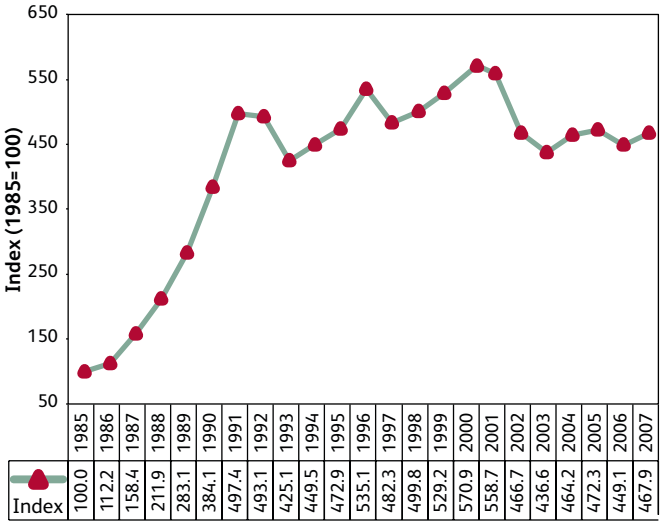


Figure 6: Indexed long term trend in drug-induced deaths in the EU-15 Member states and Norway, EMCDDA data, 1985-2007.

The low number of drug-related deaths amongst those on the CTL clearly indicates the important role that treatment has in the prevention of such deaths in the community (Table 3).

Table 3: Proportion of CTL registered patients who died from drug-related causes, HRB NDRDI data1998 – 2007.

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All CTL cases*	3,681	4,339	4,973	5,610	5,954	6,444	6,925	7,262	7,620	7,942
All CTL deaths	39	49	39	47	66	58	66	72	78	62
(%)	1.06	1.13	0.78	0.84	1.11	0.90	0.95	0.99	1.02	0.78

* Data source CTL

In the past decade the rise in drug related poisonings amongst young people from outside of the Dublin area is a strong indicator of the spread of heroin use to other parts of the county (Figure 7).

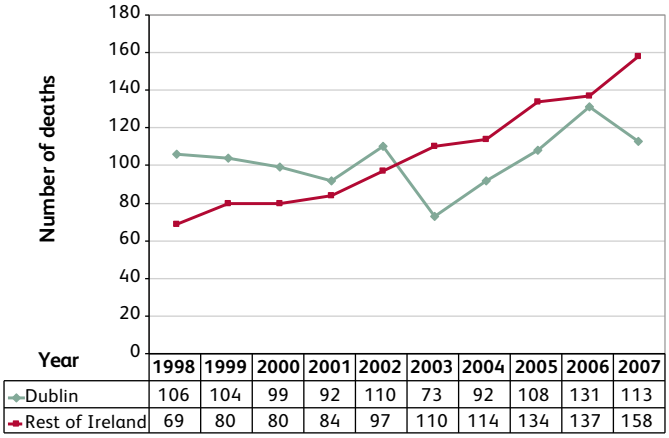


Figure 7: All recorded drug poisonings, by place of residence, HRB NDRDI data 1998-2007

Since the previous review, data has been published (Farrell and Marsden 2008; and Lyons et al 2010) that indicates a substantially elevated risk of death for people with a history of drug dependence leaving prison. The substantial growth in methadone treatment in prison in Ireland, approximately 15% of the prison population receive methadone treatment (EMCDDA 2010), and the move to link those released from prison to community treatment plays an important role in preventing overdose deaths. For this reason there is a need to expand both community and prison capacity to ensure that newly identified heroin users not in treatment can be rapidly brought into treatment in prison and have access to community treatment in all parts of the country on discharge. A working group is preparing an Overdose Prevention Strategy that is due for publication in the near future.

There is some recent English and Scottish evidence showing that introducing supervised consumption of methadone has led to a reduction in the number of deaths mentioning methadone, even when opiate substitution treatment (primarily methadone) was expanding (Strang et al 2010). Further, the risk of mortality varies at different times during and after treatment (Cornish et al 2010). We recommend that further research in Ireland explore the issues raised by these studies.

HIV and other Infectious Diseases

One of the major achievements of the past 15 years, along with countries such as Spain, France and Italy has been the containment of the spread of HIV among injecting drug users in Ireland. At the time of the proposed expansion of services in the late eighties there was major concern around rates of HIV infection and AIDS among small communities in the Dublin Inner City.

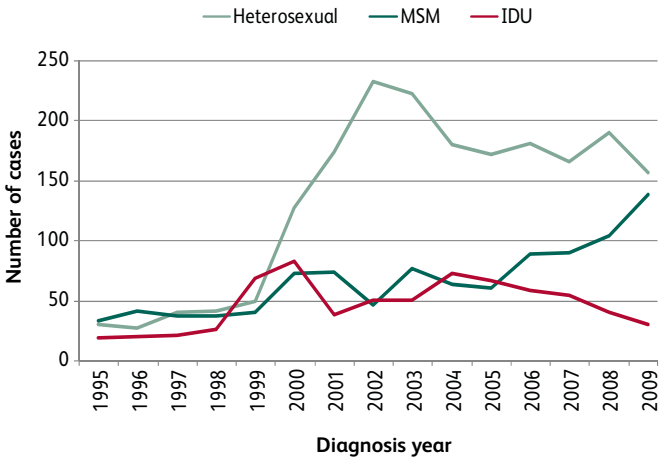


Figure 8: New HIV diagnoses in Ireland by exposure category, HPSC data, 2000 to 2009. MSM: Men having sex with men; IDU: Injecting drug users.

Over the past decade the rates of new infections have been modest and reflect the impact of the overall harm reduction strategy which combined the provision of substitution treatment and the development of needle and syringe exchange facilities. The number of new HIV diagnoses amongst injecting drug users in Ireland has more than halved over the period from 2004 to 2009, according to data from the Health Protection Surveillance Centre (Figure 8).

The success with Hepatitis C infection has not been so marked and there is a substantial sub population of current and former injectors who have chronic liver disease. The challenge of treating and managing such individuals will demand substantial medical resources over the coming decade and there have been some interesting pilot projects looking at ways to both screen for liver damage and provide anti-viral treatment for Hepatitis C Virus. The treatment of HCV among drug users needs to be expanded further. This prevalence pattern is reflected in other European member states (EMCDDA 2010).

Waiting Times for Treatment

The HSE Addiction Services provided a snapshot of the waiting times for methadone treatment for all national services as of 31 July 2010. This is detailed in Table 4 below.

Table 4: Waiting list for HSE clinics and methadone outpatient services as of 31 July 2010[1]

HSE Region		Clinic Name	Total number of people on WL as of 31 July '10	Average Waiting time (months)
HSE West	Western Area	Galway Clinic	Less than 10	1.9
	Mid West Area	Limerick Clinic	35	2.7
HSE South	Southern Area	Arbour House Clinic	11	3.7
		Kerry Clinic	Less than 10	2.7
	South East Area	Carlow Clinic	35	4.3
		Waterford Clinic	38	20.5
Dublin Mid Leinster	DTCB	DTCB	22	1.9
	East Coast Area	Arklow Clinic	Less than 10	3.4
		Baggot St Clinic	Less than 10	0.3
		Ballywaltrim Clinic	0	0
		Dundrum Clinic	0	0
		Fassaroe Clinic	0	0
		Killarney Rd Clinic	Less than 10	1.3
		Loughlinstown Clinic	0	0
		Patrick St Clinic	Less than 10	2.3
		Sallynoggin Clinic	Less than 10	1.9
	South Western Area	Aisling Clinic	18	2.4
		ARC Clinic	0	0
		Bride St Clinic	0	0
		Brookfield Clinic	0	0
		C.A.R.P	0	0
		C.A.S.P	0	0
		Castle St Clinic/Irishtown	Less than 10	0.5
		Clondalkin Lucan Clinic	22	2.3
		Cork St Clinic	Less than 10	1.4
		Drimnagh	0	0
		Dr Steevens Clinic	20	6.3
		Fettercairn Project	0	0
		Inchicore Clinic	0	0
		Jobstown Clinic	0	0
		Merchants Quay	0	0
		Old County Rd Clinic	Less than 10	0.5
		Rathmines Clinic	0	0
		Safety Net Clinic - Simon	0	0
		St Aengus Project	0	0
		Tallaght Clinic	Less than 10	0.4
	Midlands Area	Athlone Clinic	40	5.6
		Portlaoise Clinic	57	10.5

1 Note: The Average Waiting Time is based on individuals not in treatment elsewhere as per waiting lists supplied; it does not take into account those individuals who may have been put on and off the waiting list within the reporting month (throughput). This time column displays the average time (in months) that the "service user" who has been on the waiting list for treatment at a particular location. This does not take into account other interventions that occur with the "service user" i.e. assessment by a counsellor/ interaction with outreach services etc. It is also important to note that depending on clinical needs waiting times can vary significantly.
The HSE is currently refining a standard definition and national protocol concerning the criteria for waiting time calculation. This will satisfy the requirements for performance indicator recording in the future. Criteria will include validation between different waiting lists and against the CTL.

HSE Region		Clinic Name	Total number of people on WL as of 31 July '10	Average Waiting time (months)
HSE Dublin North East	Northern Area	Ballymun Satelitte Clinic	0	0
		Bonny Brook Clinic	Less than 10	2.1
		City Clinic	Less than 10	1
		Coolock Clinic	Less than 10	0
		Corduff Clinic	0	0
		Crinan Youth Project Clinic	Less than 10	1
		Darndale Clinic	Less than 10	0.9
		Domville Clinic	10	13.5
		Donabate Clinic	0	0.6
		Donnycarney Clinic	0	0
		Edenmore Clinic	Less than 10	0
		Howth Clinic	Less than 10	0.1
		Kilbarrack Clinic	Less than 10	0.3
		Mountview Clinic	0	0
		Mulhuddart Clinic	0	0
		Safety Net Clinic - Cedar	0	0
		Swords Clinic	Less than 10	1.1
		The Mews Clinic	13	2.7
		The Thompson Centre	Less than 10	0.4
		Tolco Clinic	Less than 10	0.6
		Wellmount Clinic	Less than 10	1.1
	North East Area	Meath Service	Less than 10	2.7
		Drogheda Service	Less than 10	6.9
		Cavan/Monaghan Service	10	1
		Dundalk Service	11	2.3
National Total:			445	

4.2 Update since previous review

Below is an update on key recommendations made in the previous review.

Progress on key recommendations of the Methadone Prescribing Protocol Implementation Committee (Review of the Methadone Treatment Protocol 2005)		
Summary of main recommendations	**Reponse to recommendations**	**Potential barriers to recommendations for change**
General Practitioners		
Ways of increasing the numbers of Level 1 and Level 2 General Practitioners, especially outside the HSE Eastern Regional Area should be looked at by the relevant professional body and the HSE. The research into GP Participation in the Methadone Maintenance Treatment Protocol commissioned by the ERHA could be useful in looking at this area.	The HSE has appointed a GP Co-ordinator to co-ordinate recruitment of GPs outside of the Eastern Region.	There has been progress on Level 1 GP appointments but progress has been slower on Level 2. This issues is explored in the review as it was one of terms of reference for the report
In order to respond to the needs of an expanded drug service throughout the country the nature of the role of the GP Co-ordinators should be considered. Such consideration should take place in the context of the new structures for the health service.	The GP Co-ordinator role within the East has not changed. This is being looked at in the current review.	This issues is discussed in the review as it was one of terms of reference for the report
Currently there is a cap on the number of patients who may be treated by Level 1 and Level 2 GPs. It is recommended that in certain exceptional circumstances these numbers may be increased. Any increase in the current numbers should only take place with the approval of the ICGP/HSE Review Group following an application from the GP/practice concerned. The GP/practice should meet with the necessary audit requirements of the ICGP. At all times the ethos of treating people in their own local area must be maintained.	The HSE-ICGP Audit Review Committee considers requests from individuals to increase the cap on the number of patients. For Level 1 doctors who are looking to increase to more than 15 patients, it is recommended that they undergo Level 2 training and for Level 2 doctors increases have been granted.	The overall caps for Level 1 and Level 2 is addressed in this current review.
Appropriate drug treatment training for General Practitioners applying for GMS appointments in areas of deprivation is desirable and should be considered by the Department of Health and Children.	It is not a requirement that General Practitioners applying for GMS appointments in areas of deprivation should have Level 1 training.	All GP Training Programmes should include Level 1 methadone training as part of the curriculum. So that all GPs become competent in methadone and similar type of drug prescribing

Progress on key recommendations of the Methadone Prescribing Protocol Implementation Committee (Review of the Methadone Treatment Protocol 2005)		
Summary of main recommendations	**Reponse to recommendations**	**Potential barriers to recommendations for change**
Pharmacists		
Ways of increasing the number of pharmacies involved in the scheme, especially outside of the HSE Eastern Regional Area, should be looked at by the HSE in consultation with the relevant professional bodies.	The HSE is in discussion with the Irish Pharmaceutical Union in relation to a range of matters to do with increasing the involvement of pharmacists in the methadone scheme. In addition, the Pharmaceutical Society of Ireland is represented on the Methadone Protocol Committee.	There have been financial issues that have played a part in discussions between the HSE and pharmacy representatives. These will need to be taken account of in any recommendations from the Review Committee.
Consideration should be given to the appointment of a Pharmacy Co-ordinator for HSE Areas outside the Eastern Regional Area.	There are plans in train to appoint a Pharmacy Co-ordinator outside of the Eastern region.	The National Liaison Pharmacist will be recruited by the HSE at the end of 2010. This post will provide support and supervision to pharmacists participating in the harm reduction programme outside the Dublin area.
Consideration should be given to the agreement of a contract between the HSE and pharmacists and such a contract should include provisions for audit.	Contract discussions are in progress between the HSE and pharmacists.	There have been discussions and these appear to have stalled, it is important that agreement be reached so that additional services are put in place
The Irish Centre for Continuing Pharmaceutical Education, the body charged with the provision of continuing education to community pharmacists, and the HSE should facilitate training for pharmacists in dealing with drug misusers, and where possible, liaise with relevant organisations in relation to joint training initiatives.	There hasn't been direct engagement with the Irish Centre for Continuing Pharmaceutical Education on the protocol committee.	Ongoing involvement of the Pharmaceutical Society of Ireland representative on the committee should enable formal liaison with the Centre for Continuing Pharmaceutical Education to be established if needed.
Efforts should continue to be made to foster contact and liaison between the Gardaí and community pharmacists via the Local and Regional Drugs Task Forces.	There is no systematic liaison between gardaí and community pharmacists via local arrangements with Drugs Task Forces.	There is no formal pharmacy involvement in the Local and Regional Drugs Task Forces. If there was a community pharmacy representative on the Task Forces, this would enable the liaison to happen with the Gardaí. Alternatively, Garda representatives on the Task Forces could be asked to liaise, probably via the HSE, with community pharmacists if this is deemed necessary. This also overlaps with the topic of drug service patients in garda custody and is further discussed in the report

Progress on key recommendations of the Methadone Prescribing Protocol Implementation Committee (Review of the Methadone Treatment Protocol 2005)		
Summary of main recommendations	**Reponse to recommendations**	**Potential barriers to recommendations for change**
Support Services		
Continuity of care should be a priority so as to provide a seamless service for patients. This is particularly relevant to those patients who are receiving methadone in prisons and are then released into the community at a weekend without prior arrangements being made with HSE services in relation to their care. The Committee welcomes the establishment of a Committee to develop protocols for these situations and will monitor their effectiveness, once introduced, through its ongoing work.	A committee led by the IPS and including the HSE has reconvened. Separate initiatives have taken place in Mountjoy Prison which has improved continuity significantly.	The growth in treatment provision in prisons has been very substantial and there is a need to establish clearly the benefits accruing from these impressive service developments. This should provide a stimulus for ongoing monitoring of the continuity mechanisms that have been put in place.
The under 18s group needs special consideration and the recommendations of the Working Group on this issue should be considered when published and the protocols should be adapted accordingly.	The current situation is unclear where the recommendations of the under 18s group are.	The issues for young adolescents are reviewed in this report.
Structures should be put in place to give consideration to ways in which co-ordination between the addiction and psychiatric services can be improved in order to ensure that patients with co-morbidity and needing psychiatric treatment are not disadvantaged be being on a methadone treatment programme. The committee also supports the recommendation made in the Report of the National Task Force on Medical Staffing on the appointment of consultant psychiatrists in substance misuse.	There is minimal co-ordination between addiction and psychiatric services in many areas.	The interpretation of the Vision for Change policy is proving a barrier to effective referral pathways for clients between addiction and mental health services – the overlap in these services is very substantial and needs to be strategically integrated for good quality management of complex cases.

5. Submissions

A total of 69 written submissions were received during the course of the review from a wide variety of stakeholders (appendix 1). A comprehensive summary of these submissions can be found in appendix 2.

5.1. Maximising the provision of treatment including detoxification, stabilisation and rehabilitation

A number of submissions made reference to the success of the protocol in providing methadone treatment to a large number of patients since it came into operation in 1998. There is growing demand for this service and this is confirmed by the strong sentiment among submissions for the need to expand services and address deficits. A number of suggestions emerged in relation to maximising treatment.

i. The majority of submissions highlight the need to improve local access to all services, particularly outside the Dublin area, and for there to be greater consistency in current services.

ii. It was felt that waiting times for treatment in some parts of the country were unacceptably long and this was resulting in missed opportunities with drug users.

iii. There were calls in a significant number of submissions to consider alternatives to methadone for the treatment of heroin use, specifically Buprenorphine.

iv. Shared care of patients between disciplines and greater care planning was advocated so as to provide patients with holistic and individualised care where each individual's wider needs would be identified and addressed.

v. A number of submissions called for expansion of community detoxification including greater numbers of detoxification beds in general. It was also felt by some that more could be done to support and encourage drug users to undergo detoxification.

vi. The development of treatment in primary care settings was desirable. This would include more linkages between general practice, pharmacy and community drug projects.

vii. Transfer of patients to general practice and increasing transfer from level 2 to level 1 GPs was indicated as a means of maximising treatment access and treatment capacity. In addition, some submissions argued the need to lift the GP patient caps currently in place.

viii. There were calls for greater inclusion and consideration of special groups including the homeless, travellers, pregnant women and their partners, women with children, Hep C patients and families of drug users. In order to accommodate the specific treatment requirements for these groups, it was suggested that aspects such as opening hours/weekend dispensing and more flexible overall access needed further development.

ix. The need for greater and quicker support and aftercare for patients who stabilise, complete detoxification and subsequently relapse was highlighted.

x. Some felt more information on all treatment options, and clarity around pathways into treatment, needed to be disseminated to service users and workers in the field.

xi. It was proposed that consideration be given to allowing methadone prescribing by those not included in protocol, i.e. nurses and other clinicians.

xii. A number of submissions made points about the extent of polydrug use and expressed concern that services were not addressing the needs of these patients fully.

xiii. The linkages between addiction services and mental health services are an issue for dual diagnosis patients.

5.2. To review the MTP with regard to clinical governance and audit

Just under half of the submissions made comments relating to clinical governance and audit.

i. The majority of submissions highlight the need for the development of comprehensive guidelines and protocols in relation to governance.

ii. It was felt by some that more transparency and clarity was needed around the way clinical services operate.

iii. It was felt that the role of the ICGP and the HSE in the auditing of GPs and in developing clinical guidelines needed review and that wider consultation with practitioners was needed in the future development of this area.

iv. The voice of service users, it was felt by a number of submissions, needs to be strengthened and there were calls for a transparent appeals process to be put into place to allow service users to highlight any concerns about their treatment. The issue of patient treatment sanctions, around positive urine tests, was raised in several submissions.

v. Some submissions felt that there was a need for more flexibility within the protocol.

vi. It was felt that a review was needed of the roles of the GP Co-ordinator and Liaison Pharmacist and that relations between addiction services and mental health services needed major improvement if service user needs were to be met. There was a view that mental health services stigmatise people who are on methadone treatment

vii. A few of the submissions mentioned expansion of the audit process, to cover the whole range of services and to include such things as retention in treatment, referral pathways, rehabilitation and care planning.

5.3. To review the MTP with regard to the effectiveness of referral pathways

The main points in relation to patient referrals were as follows:

i. Greater inter-agency awareness, communication, information sharing and working were needed to support effective referral pathways and continuity of care.

ii. Clear national protocols on specific referral pathways were needed.

iii. More attention and focus was needed on progression and rehabilitation.

iv. A means of increasing knowledge about the types of services available among both staff and service users should be facilitated.

v. Timely and easy transfer of patients needed, with particular attention to those areas lacking services.

vi. Rapid access to prescribing services for those who had detoxified from methadone but subsequently had relapsed to heroin or other opioid use.

vii. Particular attention given to the transfer of persons from prison into the community and the capacity of both systems to take on new patients.

5.4. To review the MTP with regard to the enrolment of GPs, the training of GPs, the criteria for level 1 and level 2 GPs, and the GP Co-ordinator role

The main points in relation to GPs:

i. Lifting GP patient caps was suggested in several submissions.

ii. The primary focus of GPs providing methadone treatment should be integrated and be part of overall general medical health care provision for the individual.

iii. More GPs should be trained and encouraged to provide methadone treatment, and training should be reviewed and broadened. More recruitment is needed in rural settings.

iv. Greater GP engagement with local projects and services was needed to ensure integrated services for patients being transferred from addiction centres.

v. GP Co-ordinators are seen as important to service development, however it was felt by some that interpretation of role is variable and more clarity is needed on what the role entails.

5.5. To review the MTP with regard to urinalysis testing, its appropriateness and efficacy

This was a contentious item across the submissions and there were conflicting views, as captured below.

i. The general consensus was that a review and evaluation was needed to align the current methods with evidence-based best practice.

ii. Whilst some felt the present frequency of weekly testing was suitable, most others felt it was too frequent and costly, and should therefore be reduced and/or randomised.

iii. The approach to testing, it was felt, needed to be standardised and some submissions noted inconsistencies in practice, particularly with reference to decisions taken and sanctions arising from positive urine tests.

iv. Benefits to testing included positive reinforcement for service users when trying to remain drug free and providing clinicians with objective measures of progress and opportunities for intervention, should relapse occur.

v. The act of supervised urine collection was challenged in several submissions, which cited it as being degrading, invasive and in violation of human rights. There were calls for alternative methods to be considered.

vi. The practice of sanctions following positive urinalysis, or against patients who refuse to provide a sample, was noted in several submissions.

5.6. To engage with the Department of Justice with regard to the prescribing of Methadone in Garda Stations

A number of submissions made comments on methadone provision in Garda Stations:

i. Several submissions stated the urgent need for national protocols and/or guidelines for the prescribing of methadone in Garda custody.

ii. Lack of access to the CTL out of hours by doctors treating patients in Garda custody was a recurrent issue.

iii. Training needs for both Garda doctors and Garda station staff were identified.

iv. Better record keeping on detainees receiving methadone is needed.

v. It was felt that better linkages with other support services and the provision of key workers would improve the care of persons in custody who use drugs.

5.7. To review the MTP with regard to data collection, collation and analysis

The following suggestions were made:

i. Additional data collection and analysis was mentioned in several submissions, to include more data on patients, longitudinal follow-up as well as more qualitative data on service user experiences.

ii. Patient tracking and the monitoring of patient progression was mentioned to facilitate inter-agency working and patient care planning. Awareness and protection of patient confidentiality should be a key part of this process.

iii. The possibility of access to data on level 1 and level 2 trained GPs was cited.

iv. Access to the CTL out of hours and expansion of the CTL to include other future treatments that may become available suggested.

5.8. Miscellaneous/outside terms of reference

The following items fell outside of the terms of reference:

i. Absence of pharmacy from terms of reference.

ii. Drug use in prisons and treatment for drug users in prison, and following transfer to and from prison.

iii. Appropriateness of methadone substitution for young patients and the need for alternative pharmacological therapies.

iv. The role and membership of the Methadone Prescribing Protocol Implementation Committee.

v. Handwriting exemptions on methadone prescriptions and review of appropriateness of current methadone prescriptions for palliative care patients.

vi. Exemption of hospitals from the MTP.

vii. Prescription of benzodiazepines and polydrug use among service users.

6. Discussion

The quality and depth of the written submissions and the high standard of engagement evident in the oral hearings augur well for the future and it is imperative that the energies and commitment of all is harnessed in providing a quality response and service.

The Protocol has worked and has been successful in terms of its original aims, and in particular it has regulated and improved poor prescribing and poor quality independent practitioner practice.

We were impressed with the clarity and focus of family, community and user groups and suggest that these voices get a more prominent place in the future planning and development of drug services. As part of the ***National Strategy for Service User Involvement in the Irish Health Service 2008-2013***, the joint HSE and DoHC charter ***You and Your Health Service*** should enable a platform for this engagement.

The importance of Primary Care Services, Mental Health Services and other Public Health aspects of problem drug users requires an imaginative integration of both organisational and clinical aspects, with the best possible model of response tailored to the needs of the service user, families and carers. A wide range of stakeholders, with a wide range of social professional backgrounds need to work together in developing a framework to support this broad service for individuals with complex needs, including major social deprivation, un-employment, family disruption and homelessness. The future challenge of homeless drug users requires good planning and the role of Safetynet and similar sort of services is important to such developments. The issue of complex families and the needs of vulnerable children in problematic families continue to grow in number and are likely to be an ongoing challenge. The needs of many children in such difficult circumstances are not being adequately addressed within the existing configuration of services. The development of the ***National Drugs Rehabilitation Framework*** is seen as an important strategic approach to developing a more holistic approach to these complex social and personal problems. There is a need to ensure strong integration between the different streams of activity. In particular, the process of long term care planning and the capacity of a range of organisations to work together require some shared care planning and a treatment pathway. However, the professional relations between some of the key medical stakeholder groups need alignment and clarification of shared responsibilities, lines of reporting and service accountability. These issues need to be addressed. This will prove an important and positive challenge for the clinical directors and managers of the service to ensure that good team functioning is achieved.

There is a large long standing polydrug using treatment population in the Dublin metropolitan area that makes considerable demands and requires complex long term management. They have a combination of social, housing, mental health and polysubstance abuse problems, including alcohol. A European study of patterns of polydrug use amongst people entering treatment for the first time found high co-use of cocaine (including crack) and alcohol in those where heroin was the primary drug. These same groups also reported high rates of cannabis use and high rates of heavy tobacco smoking (EMCDDA 2009). Several European studies have shown that the prevalence of polydrug use among methadone and buprenorphine treated patients is high. In a Barcelona cohort of treatment entrants, 30% reported polydrug use; and a Swedish study found that a third of patients were reported as having been hospitalised for the treatment of alcohol dependence. A recent Irish study on a selected group of methadone patients' reports that over half were alcohol dependent (MacManus and Fitzpatrick 2007).

Currently the biggest erosion of treatment gains is occurring as a result of the co-use of cocaine. Studies in the Netherlands, UK, Italy, and Spain all report high rates of co-use of cocaine among methadone patients (EMCDDA 2009). Co-use of cocaine is also associated with higher levels of alcohol consumption and higher levels of misuse of benzodiazepines. The co-use of cocaine is associated with significantly poorer treatment outcomes (Marsden et al 2010). There is also information to indicate that the levels of polydrug use are high in those who are not engaged in treatment. Failure to engage with treatment and dropping out of treatment is strongly associated with polydrug use.

In addition to the emergence of polydrug use as a significant burden and challenge to treatment services there is the fact that after over thirty years of service provision there is a cohort of long standing patients. The treatment data for period prevalence data from the CTL shows that there were 1,039 drug users aged 45 and over in treatment in Ireland, during September 2009. Of these, 33 were aged 60 years or older. This ageing trend will continue and the numbers while manageable, require consideration of the future service needs of older adults with alcohol and other drug problems. This type of ageing population alongside the alcohol dependent population will present a challenge to older adult services when cognitive impairment and other complex chronic co-morbid conditions complicate day to day management (EMCDDA 2008). Future planning for older adult drug and alcohol dependence needs to be part of the longer term planning process to ensure that older adult services are prepared for such contingencies.

Thus while the age of people presenting with complex drug treatment problems in Dublin has been gradually rising, regrettably there is a new cohort of younger heroin users in other parts of the country. There is a small but highly problematic group of young under-18 heroin users. There is a need for the development of national guidelines for the management of such individuals who present unique challenges. The number of youngsters aged under-18 with such problems is unclear but there is an urgent need to prepare a national strategy to guide future adolescent specialist services for such complex individuals.

Communities with long standing unemployment, social marginalisation, poverty and related issues are particularly hard hit with substance related problems. Community groups have strong views on the need for a broader perspective if these problems are to be tackled in the longer term. The ethnographic study of the Canal Communities provides a vivid picture of the deep and complex negative impact such polydrug use has on a whole community (Saris and O'Reilly 2010).

The major investment in services over the past decade has been in the Dublin area but there is now a significant heroin problem in many rural and urban areas in the midlands, the south and the west of the country. The model of services developed in the Dublin area has been shaped by particular aspects and community issues. The specific shape of many services was very significantly influenced by community attitudes towards services. Many community groups retain an understandable ambivalence towards drug services but in general the written and oral submissions demonstrated a pragmatic and realistic view on the necessity and importance of such services. Some are now calling for reconfiguration of services to try to integrate and mainstream such services to ensure that they are better linked in with other community services. A number of submissions suggested that smaller and more disseminated services seem to be a better model for planning the longer term shape of services and indicated a strong desire to move away from the very large clinics.

This review is being undertaken at a time of unique social and financial stress for the country. The issue of resources available and the best use of resources will be a critical challenge for all publicly delivered services over the coming decade. There is a need to develop systems that would enable better cost management and a better organisational grasp of the different options for the delivery of cost effective drug treatment services. It would seem clear that there is a need to have a planned approach to ensuring that services are modified to ensure that the resources are invested in a manner that ensures delivery of high impact cost effective services.

Within the system as organised it is most likely, given the block nature of funding, that many of the changes sought will be driven by the need for cost efficiencies and budgetary reduction with possible increased demand for services occurring at the same time. In this context there will be pressure for more efficient and effective sharing of services and clinical responsibilities between a wide range of professionals and a need for newer models of interagency collaboration.

There is a sense that services have developed very significantly but a strong sense that the overall quality and ambition of services requires further development. Many of the submissions particularly from service users, the community and family groups indicated a sense of frustration at some of the entrenched practices of services and the need to refresh and reinvigorate the organisation and delivery of such services.

7. Conclusions and Recommendations

7.1. Maximising treatment provision (including detoxification, stabilisation and rehabilitation) and reviewing the effectiveness of referral pathways

Supporting detoxification

Detoxification is available but there is a perception among community groups and service users that there are obstacles to accessing detoxification. In settings where there are competing demands on resources, it is important to ensure that there is a protected resource to ensure good and rapid access and ongoing support for those seeking detoxification **– requests for detoxification should have a defined time frame for response and the outcome should be reviewed for three and twelve month outcomes as part of a service audit process.** However it is important to note that detoxification alone with no other psychosocial input is not a proper treatment and there is a need to ensure that detoxification is embedded in a strong psychosocial and rehabilitative context. Overall these modalities should complement each other but there is a need for a degree of organisational co-ordination to ensure a good balance across modalities. The process of detoxification would also be assisted by a more general availability of buprenorphine and related treatment agents. **There should be a mechanism to rapidly access treatment for the six months after detoxification to ensure support if relapse occurs.** However with moves to increase capacity all should have such rapid access in the future.

Buprenorphine treatment

To date the legislation and documentation refers to methadone treatment however, in most parts of Europe, buprenorphine and buprenorpine plus naloxone are staple treatment agents. Buprenorphine to date has been provided as a small pilot feasibility project. This project is nearly complete and will provide some information on operational aspects on the use of buprenorphine. It is the review's view that buprenorphine or buprenorphine plus naloxone would provide an important expansion in treatment options and would also be useful in promoting services with pathways of progression from stabilisation to detoxification. In addition where medication is being used in the early phase of heroin or opioid dependence then buprenorphine is an important alternative option. In overall effectiveness both methadone and buprenorphine are broadly comparable in effectiveness (WHO 2008). The additional cost of buprenorphine is justified in the option it provides for alternative choice of medication. There may also be benefits in some settings from the option of alternate day dispensing. **The review recommends that the redrafting of the methadone regulations to incorporate buprenorphine and buprenorphine/naloxone treatment be urgently completed in order to expedite the full use of this drug treatment. To this end the title of the protocol needs to be changed and it is recommended that it be titled "The Opioid Treatment Protocol".**

Multidisciplinary integrated services

The review heard of community team services which have small teams with a focus on key workers and multidisciplinary work and would recommend that such models be promoted and developed in more settings. Such services could provide an important back up resource for drug services. Other services such as Soilse and Safetynet provide support and psychosocial input with a range of skilled staff. There are some very interesting models of day programmes in some geographic settings and such services provide an important bridge between different models of service. There is a large provision of FAS day programmes in some areas but none in others. It is desirable that most areas have some reasonable level of access to day programmes that assist in broader life skills and social rehabilitation and provide support for those who are wishing to detoxify.

Overall across the range of services there is a need to widen the involvement of a range of skilled professionals and also community workers who deal with issues such as housing, legal and social issues and to ensure these are better integrated into the broader service. Many of the drug services rely heavily on the doctors for the one to one consultations and regular treatment reviews. There is potentially considerable benefit from modifying services to have a range of key workers from multidisciplinary professional backgrounds including nursing and drug workers. There was an interesting example with the DTCB of the use of nurse prescribing for the management of some clinical problems; this is a model that might be expanded to other services. Such input may help to expand the range of psychosocial input for many service users.

The Department of Health and Children's policy document on mental health *A Vision for Change* presents a challenge for drug services as it only mandates psychiatric input into addiction where a dual diagnosis (mental health problem with addiction) exists. The implications of this policy need to be considered by the HSE and the mental health directorates so that better integration of the long term strategic development and delivery of mental health and addiction services aim to reduce the stigmatisation of addiction problems within the mental health services.

An integrated services approach should account for family, community and user groups and it is recommended that these voices get a more prominent place in the future planning and development of drug services. As part of the *National Strategy for Service User Involvement in the Irish Health Service 2008-2013*, the HSE and DoHC charter *You and Your Health Service* should enable a platform for this engagement.

Service development outside Dublin / rural service development

There is a need for a service model outside of Dublin that has a clear focus on rural aspects of service delivery. The range and scale of problems outside the Dublin area makes the development of services in other areas an urgent priority. There is enthusiasm and a core of interesting and differently modelled services in Galway, Limerick and Cork that requires substantial support to develop further in the next few years. **There is a need for a type of hub and spoke model that has centres of expertise but is designed to enable a much broader geographic coverage through a range of innovative service developments.** There is potential for exciting developments with alternative and new models of rural services that are very different from the long standing Dublin models and enable the development of a varied range of rural services that take account of the dispersed geographic spread required to meet service user needs. The community pharmacists also have an important contribution to make to such services.

The organisation of midwifery services for drug dependence in Dublin was impressive with a small well linked team of professionals.

Due to the unique challenges of treating under 18's and the existence of some key leaders in service delivery in the adolescent field it was felt that a national strategy was needed for development of these services that would draw on the experience of service development to date. The HSE and the DoHC published *Report of the Working Group on the Treatment Under 18 year-olds presenting to Treatment Services with Serious Drug Problems* should assist with this development.

The professional expertise of the adolescent services and the midwifery services should be used for developing an overall national strategy in these specific topics.

There is also new technology available for remote support and information provision (such as internet based CBT counselling and support, through computer based programmes or counselling by webcam) but such services are more focussed on other illegal drugs such as cannabis, ecstasy and the new stimulant drugs that are promoted through the internet.

Continuum across referral pathways from treatment to rehabilitation and care planning

The process of entry into treatment is variable with long waiting times particularly in areas where no services exist, but at times areas within Dublin were reported to develop significant waiting times (see Table 4). The assessment process at the beginning of treatment is fairly comprehensive and conducted by experienced professionals. The clear ethos is that of stabilisation with a view to review and referral depending on progress.

There is an indication that the changing patterns of drug use and the increasing use of non opiate type drugs such as cocaine requires varied approaches to both assessment and treatment planning. Such a varied mix of substance related problems requires that services use the full range of skills of the multidisciplinary team to ensure that the mixture between health and social problems is evenly addressed. This would appear to be variable across services. Approaches that promote better integration and sharing among different disciplines is likely to lead to a more flexible and innovative and responsive service. The development and discussion on care pathways and rehabilitation pathways should be of assistance in furthering this process. There are now a number of pilot projects on care planning and care pathways and the further development and integration of this into the Opioid Treatment Protocol should promote more effective use of different referral pathways. The implementation of the *National Drugs Rehabilitation Framework* provides a challenge and an opportunity for better linkages across a range of treatment modalities. The vision of the integrated care pathway is well described in this Framework, see figure 9 below.

There is a substantial sub population of drug users with Hepatitis C. The challenge of treating and managing current and former injectors who have chronic liver disease will demand substantial medical resources over the coming decade and there have been some interesting pilot projects looking at ways to both screen for liver damage and provide anti-viral treatment for Hepatitis C. This needs to be expanded further. **The treatment of HCV among drug users needs to be expanded further.**

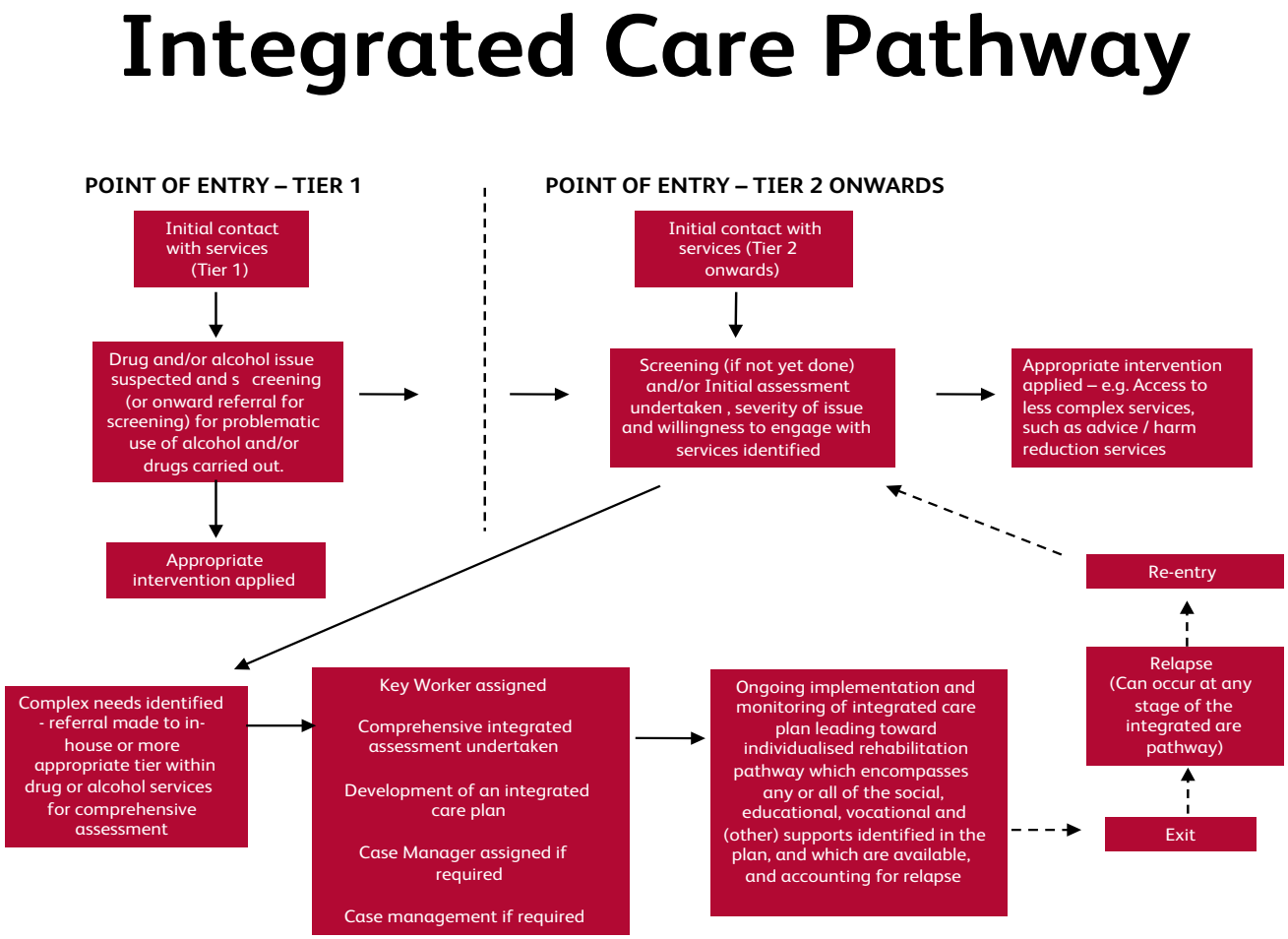


Figure 9: Integrated Care Pathway for rehabilitation, National Drugs Rehabilitation Framework, HSE 2010

Progression pathways and tiers of service

It may be possible to redefine tiers of service through the level of supervision provided to patients and for patients to progress from high level supervised services through a tier of medium level supervision to minimal supervision. In effect the progression from a large clinic to a level 2 and then to a level 1 general practitioner is such a model. This needs to be more explicitly developed and there needs to be a clear mechanism of monitoring and promoting progression through the tiers of service in order to enhance treatment capacity. **There is need to create a sense of progression within services either through the tiers of the services or alternatively through the detoxification and rehabilitation pathway, with movement within and between these pathways being actively promoted through a variety of mechanisms.**

Electronic care planning and outcome monitoring

There has been a major investment in the expansion and delivery of treatment but there are still blocks in the system and considerable variation in access in different parts of the country. **There is a need to develop a more structured care planning process. In clinical practice much of this seems to take place but there is a need to make this process more explicit and to ensure that the documentation around it is better structured and agreed and shared across a range of different agencies.**

The services need to develop to the stage where every individual has a clearly documented care plan that is subject to a regular review and update. The care plan should be fully drawn up within the first three months of treatment and should clearly document the patients' aims and goals for treatment and outline the range of treatments required to achieve the patients' goals. This plan should be fully reviewed and modified at twelve months and measured against whether the stated goals have been achieved. This may help keep a focus on achieving detoxification for those who regard it as their main goal. It will also help to focus long term methadone maintenance service users on important dimensions of their lives such as education, training and employment.

The development of an electronic record of care planning is necessary if proper care planning is to be comprehensively implemented. The DTCB's Electronic Patient System is a concise and well developed system that could be readily incorporated as the national standard for care planning. Such a document should be confidentially shared across a full range of agencies. This care planning approach should be rapidly and comprehensively applied across all drug services nationally. This would be a major step forward in care planning. The monitoring process and outcome recording process should provide an accurate picture of the range of people who achieve clinically significant stabilisation and also give a clear indication of the numbers achieving a planned exit post detoxification.

It would be helpful to set targets for the numbers expected to achieve detoxification or progression to other types of rehabilitation services. This would be helped by the development of some simple outcome measure where the outcomes of different services could be compared and such data could be used to identify good models of practice as a way of supporting and promoting best models of practice. An example of such a measurement instrument is the Treatment Outcome Profile (Marsden et al 2010). This is available for adaptation and **it is recommended that the implementation of a once yearly completion of such a brief instrument would provide important information on the performance of individuals and on the overall performance of the service. Such an outcome instrument should also be completed for everyone at the end of a treatment period.**

7.2. Clinical governance and audit

Clinical governance

There is a challenge for services in that the structure of the HSE is changing and there is a need to ensure that the organisation and delivery of drug treatment services is kept abreast of this. The HSE document on *Achieving Excellence in Clinical Governance: towards a culture of accountability* (2010) provides a clear framework for the future drug services to review and adopt new structures for organisational accountability. The new clinical directors in partnership with Addiction Services Managers should enable a good working partnership between clinical and managerial aspects of the service. In the new services it is important that the clinicians involved in day to day service delivery have a representative voice in the organising, planning and delivery of services. Each sector will have a clinical director who will be responsible for ensuring sound clinical governance. The clinical director

will work within the new national structures and hopefully have authority to ensure that a sound and safe service is developed. **In the area of the drug service, given the wide range of professionals involved, it is desirable that there be some option for flexibility around who is appointed clinical director. It is desirable that the director have a background, and training to the level recognised as an Addiction Specialist.**

Given the high level of training of doctors, nurses, pharmacists, counsellors, social workers, psychologists, community workers, and others, there is a strong foundation for the further development of a safe and sound and reliable and confidential service. The challenge for the existing service is to develop a framework of accountability that meets the expected standards of a 21st Century health and social care delivery system. Within some services there is a considerable lack of clarity in lines of reporting and accountability; the Addiction Services Manager and the Clinical Director need to directly address this. **The lines of reporting and accountability in all of the services requires review so that all professionals have their within service reporting lines clarified.** The document *Achieving Excellence in Clinical Governance* contains a section on the development of Clinical Governance that is a good and clear step by step model that should be fully applied within all the drug services.

Audit development and extension

The development of general practitioner audit has worked well and has been actively engaged with by all the practitioners involved. The future of it will require streamlining and the pilot development of peer audit is welcomed. The development of audit in one part of the system however makes clear the need for a broader use of audit within the drug services. We note the significant work that has gone into developing audit by the ICGP. **Audit should now be developed across the full range of drug services where standards around practice could be reviewed.**

The audit in services could be developed to monitor the implementation of care plans and the review of care plans, or the audit of prescribing of other psychoactive drugs such as benzodiazepines. **The audit process should also be used to monitor treatment drop-out and other aspects of treatment services that could be agreed to be quality indicators.**

As part of this process in both written and oral submissions there was a consistent call for the development of joint guidelines that would enable benchmarks to be set against which future audits could be measured. Such guidelines should be developed by a joint working group of the College of Psychiatry of Ireland and the Irish College of General Practitioners with input from relevant other professional groups such as pharmacy.

The parallel development of primary care teams could assist in providing additional framework for supporting and developing professional practice and ensuring that new level 1 general practitioners have a supportive framework for developing their practice.

There has been a major expansion in delivery of drug treatment to prisoners, and there is a need to link this up with the community based services. Auditing of the linkages to community services on discharge from prison and the use of the standard care planning electronic document would assist in linking these services together to improve overall patient outcomes.

Clinical guidelines on benzodiazepine prescribing

The CTL has provided data that enables a clear picture of current clinical practice and ensured or minimised duplicate prescribing of opiates, but has not done this for benzodiazepine prescribing. There was a review of benzodiazepine prescribing *Report of the Benzodiazepine Committee* (DoHC 2002) and the recommendations of it were not taken forward. While benzodiazepine prescribing has not been within the direct terms of reference of this review there is a need for a concerted approach to achieving tighter and more responsible prescribing of benzodiazepines. In particular, **recommendation 10 from this report:**

Clinic doctors should communicate with clients' general practitioners involved in the treatment of drug misusers regarding the prescribing of benzodiazepines. In most cases the clinic should, with the agreement of the general practitioner, take responsibility for the prescribing of benzodiazepines and so prevent double or multi-prescribing to known drug users

should be implemented.

During the oral hearings the Pharmaceutical Society of Ireland demonstrated a strong interest in playing a part in improving the standards of prescribing of benzodiazepines. This work needs further development and should be undertaken as soon as possible in order to reduce poor benzodiazepine prescribing practice across all sectors of services in the HSE.

7.3. The enrolment of GPs, the training of GPs, the criteria for level 1 and level 2 GPs, and the GP Co-ordinator role

One of the important aims of the MTP was to promote responsible and good GP involvement in this form of treatment. The National GP Co-ordinator has undertaken a major task in increasing the number of doctors involved and on balance this has been successful. **The level of training for level 1 GPs is such that in the near future it should be an expectation that all trainees completing GP training have demonstrable competence to meet criteria for level 1**, thus ensuring that all new contracts and newly trained GPs meet level one competence.

There is however a smaller growth and some more problems with the training of level 2 GPs in that it requires a period of time managing a small case load of patients, and this has resulted in a very limited number of level 2 GPs outside Dublin. **There is a need to expand the number of level 2 general practitioners.**

If the original intention of the MTP was that patients should move through the system with a flow from level 2 to level 1 GPs, this has had limited success. In some areas there has been a clear movement and the ongoing development of treatment capacity through the ongoing movement of patients from Level 2 to more disseminated level 1 practices. It would appear that in some areas the GP Co-ordinators have not been effective in moving patients on. The number of patients moving from level 2 to level 1 GPs is less than 5% annually across the last decade (Table 2). This is a major blockage in the system of improving capacity. There is a need for more active management of this process. **There should be a stated time limit for patients to be with level 2 GPs and they should ensure that the patient moves on to a level 1 GP within 12 months. There may be exceptional cases that require longer term management at level 2 but there is a need for concerted handling and processing through to level 1 GPs.**

There are a number of other potential drivers. **Level 2 GPs are requesting a change of the cap on numbers to be raised from 35 to 50. The review recommends that this be done.**

The review does not think that the cap on the number of patients with level 1 GPs has any great function and would suggest that such a cap be abolished.

Overall there was significant disparity in the role and function of GP Co-ordinators. Specifically their role in promoting movement from Level 2 to Level 1 GPs has been underwhelming. For Dublin and the East there are five GP Co-ordinators. There is variation in how they work and how they are perceived and they did not present as a united group. This may be partly because they have a range of tasks which have different priorities in different services. **We recommend that roles of the GP Co-ordinators be overhauled and the task of moving patients from level 2 to level 1 GPs be prioritised, in conjunction with local management. There should be significant headway made on this by September 2011.** These posts should be subject to ongoing review as to their utility and viability and that one of the key measures be the actual numbers of patients moving from Level 2 to level 1 GPs.

In other regions such as the West and the South West, there are examples of GP nurse liaison practitioners who work to both support and move patients on. This model of practice should be further developed.

The National GP Co-ordinator has done sterling work in filling gaps and supporting new development and recruiting and supporting new practitioners where no other support was available. With the ongoing development of services in different parts of the country there is a need for more local support and input to service development. **As new structures evolve the National GP Co-ordinator post should be reviewed to ensure it remains fit for purpose.**

The ICGP and the lead function within the ICGP remains an important and functional role in promoting audit and training.

7.4. Urinalysis testing, its appropriateness and efficacy

There was some strong views among professionals, community and user groups on the limitations and other aspects of drug urine testing and monitoring. The criticism is that the services rely too heavily on the use of urine testing. The other criticism is that both the practice and the decisions based on results are variable and dependent on the views of different doctors within individual services. There is some overall difference in these views with the clinics being more involved in structured services that involve urine testing and those who have moved out to Level 1 GPs requiring less and getting less urine testing. Some clinics reportedly undertook twice weekly testing for a significant period of time, and also some clinics reported fairly regular testing even for people in long and sustained periods of treatment.

There is a need to take a fresh approach to monitoring and quality control within services with respect to urinalysis. The testing methods have become too entrenched and some of the time spent carrying out such tests under supervision could be more usefully spent in assessing a broader range of issues and looking at a more holistic care planning approach. The current frequency of testing at any stage is only likely to detect very frequent use which much of the time is clinically obvious. Clearly the other role of testing is to determine compliance with the consumption of the prescribed medication. A truly random approach and an approach of testing on reasonable grounds of concern, could significantly reduce the amount of testing and make the use of such testing more meaningful (Goldstein and Brown 2003; DuPont 2003). The use of consecutive testing as the basis for deciding take away doses, is likely to lead to cheating and distortion and unlikely to be maintained if it is simply on that basis. A wider clinical assessment, with a broader care plan and focus on clinical progress on a number of dimensions would be a more acceptable approach from the service user perspective.

It would seem practical to significantly reduce the frequency of testing and to apply it on a more random basis and to shift some of the resource currently expended on organising urine testing into more key working and other related activities.

There are a number of options but overall there is a potential for substantial savings, without any material reduction in the quality of service. **It is recommended that frequent testing be stopped because it is not conducted often enough to be comprehensive and it mainly captures behaviour that is daily regular drug taking behaviour.**

The supervision of urine testing should be eliminated except where there is a legal requirement for supervision and that oral fluid or urine bottle temperature testing be used to indicate whether a fresh sample is being provided.

Recently the technology behind oral fluid testing has improved substantially and it now possible to undertake on site saliva testing. With the elimination of supervision and the reduction in frequency and the ability to conduct such tests for immediate interpretation the utility and user friendliness of such an approach would be attractive to many service users and should be implemented as soon as possible.

With these changes consideration should be given to piloting one or two contingency management treatment programmes to assess the viability of such a service within the Irish context of service provision.

With the move to less frequent urine testing **it would be desirable to introduce a mechanism for systematic monitoring of the levels of supervision of methadone, buprenoprhine and buprenorphine / naloxone consumption**. Currently, the anecdotal evidence is that the vast majority of patients have to consume some of their prescription under supervision but in a small number of cases the doctor specifies no supervision.

The practices of different treatment systems have been reviewed, including the US, Canada, Australia, and some European countries (see appendix 4 for list of sources). The general trend is towards less frequent and random testing, that is on site so that the results can be used immediately.

Earlier it was recommended that **the Irish College of General Practitioners and the College of Psychiatry of Ireland, along with other colleagues jointly produce guidelines and it is suggested that one aspect of the guidelines be focussed on high quality approaches to the monitoring of treatment impact which would include approaches to drug testing. This overall change, which should result in a major reduction in the frequency of urine testing and the elimination of supervision, needs to be implemented by the clinical teams and it is recommended that the detailed implementation of this be part of the joint guidelines developed by the ICGP and the College of Psychiatry of Ireland. It is also recommended that such guidelines be completed at the latest by September 2011.**

7.5. The prescribing of Methadone in Garda stations

There is an absence of any explicit governance structure for the delivery of methadone treatment in Garda stations. There does not appear to be any identified mechanism or standards by which doctors are recruited or contracted to undertake these responsibilities. Further, there are no clear Standard Operational Procedures by which to assess the current practice.

There does not appear to be any clear method of clinical recording of doctors' assessments or decision within a personal health record that can be transported with the individual as they move through the system in an appropriate and confidential manner, as a personal health record.

There are very varied practices by which methadone is obtained in different settings. Procedures where individual Gardai collect and supply methadone to patients would seem to put Gardai at very high risk of serious criticism should there be any adverse outcomes associated with the methadone consumption.

There is a need for a fundamental review of the procedures and systems for medical assessment of people in custody.

There is a need for clear and explicit guidelines for the management of opioid dependence while in Garda custody. A working group with a relevant range of stakeholders should be urgently established.

The overall health care input to Garda stations should be reviewed with consideration that operational responsibility and financial aspects of this service be transferred to become a responsibility of the HSE.

The doctors attending Garda stations should be at a minimum level 2 trained GPs. In the first instance they should be trained to level 1 within six months of the publication of this report, and be competent at level 2 in order to ensure safe initiation of methadone treatment a year after gaining level 1 competence.

Doctors attending users in Garda stations should have access out of hours to the CTL and should also be able to obtain information from pharmacists on the last time of medication dispensing.

This review recommends that the Garda stations come under the new Opioid Treatment Protocol.

7.6. Data collection, collation and analysis

The CTL has provided data that enables a clear picture of current clinical practice and ensured or minimised duplicate prescribing of opiates, but has not done this for benzodiazepine prescribing.

The past decade has seen major investment and major expansion of drug treatment services. The overall data on the current situation is of a high quality and has been of significant assistance in undertaking this review

In developing a care planning approach, consideration should be given to the broader utility of this data monitoring with a view to some brief outcome monitoring process being built into this, where the status of an individual is systematically recorded on a once yearly basis. This would enable strategic development of a process where the services gradually moved towards reporting on overall outcomes as a core part of service organisation, planning and delivery.

The Health Research Board (HRB) undertakes substantial work in monitoring the activities of the treatment process. **There should ideally be a systematic approach that enables wider data linkage through possible use of the PPS number that would enable ongoing mortality and other service utilisation analysis.** Such work would help in tracking the pathways and careers of service users and provide valuable information on the long term outcomes of users.

The review has outlined earlier the potential for the use of electronic care planning and also recommended the introduction of systematic outcome monitoring. There is a need to ensure that the infrastructure and resource required for this is strongly supported. A modest investment in such a development will make for a potentially major impact on both research and service monitoring and is likely to be a potential model for broader implementation across the HSE.

There are a number of agencies that have responsibility for information systems and research. These include the National Advisory Committee on Drugs, the HRB, the HSE (and in particular the CTL), the Department of Health and Children, and the Department of Community, Equality and Gaeltacht Affairs. Much effort goes into the collection of data which is generally quality controlled and well validated. **The review team believes that there is much to be gained from the linkage of information from different data sources but this is currently not permissible under Data Protection legislation. We recommend legislative change to make this permissible.**

We also recommend the establishment of a group comprising the main data controllers so that maximum use can be made of the data collected, in a secure and confidential environment with appropriate privacy protection.

7.7. Miscellaneous/outside terms of reference

The following items fell outside of the terms of reference

i. Absence of pharmacy from terms of reference and handwriting exemptions on methadone prescriptions. Submissions were received from the Irish Pharmacy Union, the Pharmaceutical Society of Ireland, and Pharmacists in the Addictions. Oral evidence was taken from all three and the issue of progress on handwriting exemptions for controlled drugs was explored. **We concluded that it was beyond time for the introduction of a handwriting exemption procedure. In further discussion with the Department of Health and Children, it seemed clear that this process would be expedited.** Further work is in process looking at the issue of electronic prescribing and this is part of a larger review of electronic prescribing across all health care. There was also information provided on a common EU prescription template that is in development that would enable wider European travel and utilisation of such a prescription to obtain treatment in other EU countries. This requires further work but is of interest both for patients travelling abroad but also for individuals who might travel to Ireland who would require medication.

ii. Nurse prescribing of controlled drugs should be explored and if possible developed further in line with international practice. The view of the review is that the further development of such multi-professional practice could be advantageous to overall service organisation and service flexibility and should be explored further with the aim of training a number of nurses in order to undertake pilot projects of such practice.

iii. Drug use in prisons and treatment for drug users in prison, and following transfer to and from prison. Since the last report there has been a major expansion of drug treatment in prisons and there is a need to address the capacity of community drug service provision in order to ensure that users in prison get access to longer term treatment. There are a significant number of users in prison who do not receive ongoing treatment in prison because of the inability of the prison services to ensure ongoing access to treatment after release. **There is a need for better linkage and for ensuring priority access of prisoners to community based treatment after release from prison.**

iv. Appropriateness of methadone substitution for young patients and the need for alternative pharmacological therapies. **There has been some significant development of adolescent services for opioid dependence and a case was made for the availability of other medications such as buprenorphine for use in young people with a short history of heroin use. The review agrees that the availability of this medication for this target group would be a positive step.**

8. List of Recommendations

The HSE commissioned Professor Michael Farrell, Professor of Addiction Psychiatry at Kings College London to carry out this review. He was assisted by Professor Joe Barry, Professor of Population Health Medicine at Trinity College Dublin. The administration and project support for this review was provided by Jelena Ivanovic. This is the first external review of the methadone treatment protocol. The review consisted of a mixture of written submissions and oral hearings focussed on pre-defined key terms of reference. The full report outlines a summary of the submissions and all recommendations are listed below.

1. Maximising treatment provision and the efficacy of referral pathways

1.1. Requests for detoxification should have a defined time frame for response and the outcome should be reviewed for three and twelve month outcomes as part of a service audit process.

1.2. There should be a mechanism to rapidly access treatment for the six months after detoxification to ensure support if relapse occurs.

1.3. The redrafting of the methadone regulations to incorporate buprenorphine and buprenorphine plus naloxone treatment should be rapidly completed. The introduction of these agents into the treatment system should be expedited to ensure a broader range of treatment options, including the treatment of opioid dependent adolescents. To this end the title of the protocol needs to be changed and could be titled "The Opioid Treatment Protocol".

1.4. Services with a focus on key workers and multidisciplinary work should be promoted and developed in more settings.

1.5. An integrated services approach should account for family, community and user groups and it is recommended that these voices get a more prominent place in the future planning and development of drug services. As part of the *National Strategy for Service User Involvement in the Irish Health Service 2008-2013*, the HSE and DoHC charter *You and Your Health Service* should enable a platform for this engagement.

1.6. There is a need for a service model outside of Dublin that has a clear focus on rural aspects of service delivery. The range and scale of problems outside the Dublin area makes the development of services in other areas an urgent priority. There is a need for a type of hub and spoke model that has centres of expertise but is designed to enable a much broader geographic coverage through a range of innovative service developments.

1.7. In areas where the service currently relies on doctors travelling from Dublin to provide a service, it is desirable that more permanent local medical input is organised in the near future for the purposes of continuity of service delivery.

1.8. The professional expertise of the adolescent services and the midwifery services should be used for developing an overall national strategy in these specific topics.

1.9. Implementation of a once yearly completion of a brief instrument, such as the Treatment Outcome Profile, would provide important information on the performance of individuals and on the overall performance of the service. There is need to create a sense of progression within services either through the tiers of the services or alternatively through the detoxification and rehabilitation pathway, with movement within and between these pathways being actively promoted through a variety of mechanisms.

1.10. Services should use the full range of skills of the multidisciplinary team to ensure that the mixture between health and social problems of drug users is evenly addressed.

1.11. The treatment of Hepatitis C Virus among drug users needs to be expanded further.

1.12. There is a need to develop a more structured care planning process. In clinical practice much of this seems to take place but there is a need to make this process more explicit and to ensure that the documentation around it is better structured and agreed and shared across a range of different agencies. The services need to develop to the stage where every individual has a clearly documented care plan that is subject to a regular review and update. The care plan should be fully drawn up within the first three months of treatment and should clearly document the patient's aims and goals for treatment and outline the range of treatments required to achieve the users goals. This plan should be fully reviewed and modified at twelve months and measured against whether the stated goals have been achieved.

1.13. The development of an electronic record of care planning is necessary if proper care planning is to be comprehensively implemented. The DTCB's Electronic Patient System is a concise and well developed system that could be readily incorporated as the national standard for care planning. This care planning approach should be rapidly and comprehensively applied across all drug services nationally.

2. Clinical governance and audit

2.1. It is desirable that there be some option for flexibility around the appointment of HSE clinical directors. It is desirable that the director have a background and training to the level recognised as an Addiction Specialist.

2.2. The lines of reporting and accountability in all of the services requires review so that all professionals have their within service reporting lines clarified.

2.3. Audit should now be developed across the full range of drug services where standards around practice could be reviewed.

2.4. The audit process should also be used to monitor treatment drop-out.

2.5. The development of joint guidelines that would enable benchmarks to be set against which future audits could be measured. Such guidelines should be developed by a joint working group of the College of Psychiatry of Ireland and the Irish College of General Practitioners with input from relevant other professional groups such as pharmacy.

2.6. There has been a major expansion in delivery of drug treatment to prisoners, and there is a need to link this up with the community based services. Auditing of the linkages to community services on discharge from prison and the use of the standard care planning electronic document would assist in linking these services together to improve overall patient outcomes.

2.7. During the oral hearings the Pharmaceutical Society of Ireland demonstrated a strong interest in playing a part in improving the standards of prescribing of benzodiazepines. This work needs further development and should be undertaken as soon as possible in order to reduce poor benzodiazepine prescribing practice across all sectors of services in the HSE.

2.8. Recommendation 10 from the Report of the Benzodiazepine Prescribing Committee (2002), which states:

"Clinic doctors should communicate with clients' general practitioners involved in the treatment of drug misusers regarding the prescribing of benzodiazepines. In most cases the clinic should, with the agreement of the general practitioner, take responsibility for the prescribing of benzodiazepines and so prevent double or multi-prescribing to known drug users."

should be implemented.

3. Enrolment of GPs, training of GPs, the criteria for level 1and level 2 GPs, and the GP Co-ordinator role

3.1. The level of training for level 1 GPs is such that in the near future it should be an expectation that all trainees completing GP professional training have demonstrable competence to meet criteria for level 1.

3.2. There is a need to expand the number of level 2 general practitioners.

3.3. There should be a stated time limit for patients to be with level 2 GPs and GP Co-ordinators should ensure that the patient moves on to a level 1 GP within 12 months. There may be exceptional cases that require longer term management at level 2 but there is a need for concerted handling and processing through to level 1 GPs.

3.4. Level 2 GPs are requesting a change of the cap on numbers to be raised from 35 to 50. We recommend that this be done.

3.5. The cap on the number of patients with level 1 GPs should be abolished.

3.6. The roles of the GP Co-ordinators should be overhauled and the task of moving patients from level 2 to level 1 GPs be prioritised, in conjunction with local management. There should be significant headway made on this by September 2011.

3.7. There are examples of GP nurse liaison practitioners who work to both support and move patients on. This model of practice should be further developed.

3.8. As new structures evolve the National GP Co-ordinator post should be reviewed to ensure it remains fit for purpose.

4. Urinalysis testing, its appropriateness and efficacy

4.1. Frequent urine testing should be stopped. It is not conducted often enough to be comprehensive and it mainly captures behaviour that is daily regular drug taking behaviour.

4.2. The supervision of urine testing should be eliminated except where there is a legal requirement for supervision and that oral fluid or temperature testing be used to indicate whether a fresh sample is being provided.

4.3. The technology behind oral fluid testing has improved substantially and it is now possible to undertake on site saliva testing. With the ability to conduct such tests for immediate interpretation the utility and user friendliness of such an approach would be attractive to many service users and should be implemented as soon as possible.

4.4. The Clinical Guidelines jointly developed by the ICGP and the College of Psychiatry of Ireland should include an implementation plan for the move to less urine testing and a greater clinical focus on the use of the results of drug testing samples. This overall change, which should result in a major reduction in the frequency of urine testing and the elimination of supervision, needs to be implemented by the clinical teams and it is recommended that the detailed implementation of this be part of the joint guidelines developed by the ICGP and the College of Psychiatry of Ireland. It is also recommended that such guidelines be completed at the latest by September 2011.

4.5. Consideration should be given to piloting one or two contingency management treatment programmes to assess their viability.

4.6. It would be desirable to introduce a mechanism for periodic monitoring of the levels of supervision of methadone and buprenoprhine and buprenorphine/naloxone consumption.

5. Methadone prescribing in Garda stations

5.1. There is a need for a fundamental review of the procedures and systems for medical assessment of people in Garda custody.

5.2. There is a need for clear and explicit guidelines for the management of opioid dependence while in Garda custody. A working group with a relevant range of stakeholders should be urgently established.

5.3. The overall health care input to Garda stations should be reviewed with consideration that operational responsibility and financial aspects of this service be transferred to become a responsibility of the HSE.

5.4. The doctors attending Garda stations should be at a minimum level 2 trained GPs. In the first instance they should be trained to level 1 within six months of the publication of this report, and be competent at level 2 in order to ensure safe initiation of methadone treatment a year after gaining level 1 competence.

5.5. Doctors attending users in Garda stations should have access out of hours to the CTL and should also be able to obtain information from Pharmacists on the last time of medication dispensing.

5.6. Garda stations should come under the Protocol.

6. Data collection, collation and analysis

6.1. In developing a care planning approach, consideration should be given to the broader utility of this data monitoring with a view to some brief outcome monitoring process being built into this, where the status of an individual is systematically recorded on a once yearly basis.

6.2. There should ideally be a systematic approach that enables wider data linkage through possible use of the PPS number that would enable ongoing mortality and other service utilisation analysis. Such work would help in tracking the pathways and careers of service users and provide valuable information on the long term outcomes of users.

6.3. There is a need for legislative change to allow the linkage of data from different data sources.

6.4. We recommend the establishment of a group comprising the main data controllers so that maximum use can be made of the data collected, in a secure and confidential environment with appropriate privacy protection

7. Others

7.1. Handwriting exemption procedures should be introduced.

7.2. Nurse prescribing of controlled drugs should be explored and if possible developed further in line with international practice. The view of the review is that the further development of such multi-professional practice could be advantageous to overall service organisation and service flexibility and should be explored further with the aim of training a number of nurses in order to undertake pilot projects of such practice.

7.3. There is a need for better linkage and for ensuring priority access of prisoners to community based treatment after release from prison from all Irish prisons.

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Appendices

Appendix 1

2010 Review of the Methadone Treatment Protocol

Record of submissions

No.	Name / Organisation
1.	Dr. Garrett McGovern*
2.	HSE Addiction Services Dublin Mid-Leinster South Western Region*
3.	Aiseiri
4.	Ballyfermot STAR*
5.	SharingPoint
6.	Linda Latham, thesis submission (unpublished)
7.	Liam O'Brien, CARP-Killinarden*
8.	Irish Pharmacy Union*
9.	Dun Laoghaire & Rathdown Local Drugs Task Force Treatment & Rehabilitation Sub Group
10.	Clondalkin Addiction Support Programme (CASP)*
11.	Waterford Substance Misuse Service
12.	Dr. Sean Ó Domhnaill
13.	Dr. Hugh Gallagher*
14.	Dr. Cathal Ó Súilliobháin*
15.	Southern Region Drugs Task Force*
16.	Bray Local Drugs Task Force*
17.	Office of the Minister for Drugs*
18.	Northern Area Voluntary Cluster*
19.	Rialto Rights in Action*
20.	Traveller Specific Drugs Initiative
21.	North Inner City Drugs Task Force Treatment & Rehabilitation Sub Group*
22.	Crosscare Drug and Alcohol Programme*
23.	Deirdre Carmody, Drug Liaison Midwife, HSE*
24.	Julian Pugh, Co-ordinator Drug Treatment Services (Prisons)
25.	Dr. Fidelma Savage*
26.	SAOL Project*
27.	Dr. John Moloney*
28.	Tabor Lodge
29.	HSE Addiction Service North Dublin, Sector Management Team*
30.	SOILSE, Service Users
31.	SOILSE, Staff*
32.	County Wicklow Community Addiction Services Ltd.
33.	Dr. Colm Quinn*
34.	McGarry House
35.	Dr. Paul Quigley
36.	Dublin North East Drugs Task Force Treatment & Rehabilitation Sub Group
37.	Dr. Declan O'Brien and Dr. Don Coffey*
38.	Aaron Keegan, Euromedic Lablink
39.	SafetyNet Primary Care Network*
40.	Irish Medical Organisation*
41.	Family Support Network*
42.	Chair, National Drug Rehabilitation Implementation Committee*

No.	Name / Organisation
43.	Ballyfermot Advance Community Drugs Team*
44.	Clondalkin Local Drugs Task Force*
45.	GPSSA CME*
46.	DTCB*
47.	Ballymun Local Drugs Task Force Treatment & Rehabilitation Sub Group*
48.	Kilbarrack Coast Community Programme
49.	Dr Desmond Crowley*
50.	Dr. Eamon Keenan, Dr. Brion Sweeney, Dr. John O Connor, Dr. Bobby Smyth, Dr. Siobhan Rooney, Dr. Gerry McCarney, Dr. Mike Scully & Dr. William Flannery, Consultant Psychiatrists in Substance Abuse*
51.	Nihal Zayed, Dr. Denis O'Driscoll, Helen Johnston & Joanne O'Brien, Pharmacists in Addiction Services*
52.	Sex Workers Alliance Ireland
53.	Marie Wright, Senior Pharmacist
54.	Dr. Patrick Troy
55.	South Western Regional Drugs Task Force
56.	Citywide*
57.	Tallaght Local Drugs Task Force*
58.	Dr. Moosajee Bhamjee
59.	JADD Project
60.	Irish Association of Alcohol and Addiction Counsellors*
61.	North Dublin City & County Regional Drugs Task Force
62.	Cornmarket Project Wexford
63.	UISCE*
64.	Pharmaceutical Society of Ireland*
65.	Medical Staff Committee, Addiction Services HSE Dublin North East*
66.	HSE Social Inclusion*
67	HSE Addiction Services GPs*
68	Irish College of General Practitioners*
69	Department of Justice and Law Reform*

* Representatives attended oral hearings. In addition the following representatives also attending oral hearings:

An Garda Siochána
Ballyfermot Local Drugs Task Force
Canal Communities Local Drugs Task Force
Department of Health and Children
Donnycarney Youth Project
Dr Jim Moloney & Dr Conal Hooper, Garda Doctors
Dr Margaret Burke, GP Co-ordinator
Inchicore Community Drugs Team
Irish Prisons Service
Fusion CPL
Justin Gleeson
Moutview/Blakestown Community Drugs Team
Mulhuddart/Corduff Community Drugs Team

Appendix 2

Summary of Submissions

	Terms of Reference
1	To review the MTP with regard to maximising provision of treatment including detoxification, stabilisation, and rehabilitation
2	To review the MTP with regard to Clinical Governance and audit
3	To review the MTP with regard to effectiveness of referral pathways
4	To review the MTP with regard to the enrolment of GP's, the training of GP's, the criteria for Level 1 and Level 2 GP's, and the GP co-ordinator role
5	To review the MTP with regard to urinalysis testing; its appropriateness and efficacy
6	To engage with the Department of Justice with regard to the prescribing of Methadone in Garda Stations
7	To review the MTP with regard to data collection, collation and analysis

1. To review the MTP with regard to maximising provision of treatment including detoxification, stabilisation, and rehabilitation

Sub. ID	Source if individual	Organisation	Submission
1	Dr Garrett McGovern		There needs to be a dedicated unit to treat all chaotic drug users - more stabilisation beds. There are a significant number of drug users who, despite treatment, continue to misuse drugs and/or alcohol and have complex psychosocial needs. These patients have high mortality and would benefit from respite care in a stabilisation unit where they are not forced to come off opioid agonist therapy. The only units that exist for this purpose are Cuan Dara and Beaumont Hospital. Unfortunately the criteria for entry usually preclude most groups, other than pregnant and HIV positive patients.
			Community projects vital. These are a vital component of drug treatment in this county and should not have their funding cut any further.
2		HSE Addiction Services Dublin Mid-Leinster South Western Region	Promotion of shared GP-Community based detox. Consideration should be given to promoting patient led community detoxification within GP practices in the community. A shared care model of support should be included to facilitate this type of initiative.
			NDRIC National Rehabilitation Framework highlighted. The Addiction Service welcomes the report but is conscious that there will be significant challenges in operationalising the report in the current resource constrained environment and that the community/voluntary/statutory interface indicated in the report needs management.
3		Aiseiri	Extension of services to include: the option of planned reduction of dependence on methadone and the possibility of converting these clients to a drug free option; the option of detoxification; counselling for those on a methadone programme to ensure the best quality of life is achieved; and funding of intensive residential treatment for opiate users who wish to live drug & medication free lives
4		Ballyfermot STAR	Waiting lists. Clinic in Ballyfermot presently has a waiting period of 1 year for a methadone maintenance place. This creates great difficulties to individuals and their families. It also creates a market for methadone to be sold on the street.
			Shared care with GPs. If clear treatment plans are created with the doctor, key worker and patient, the key worker could be a support to the individual to carry out set agreed goals. The key worker could also be a resource to the doctor. Organisation such as Ballyfermot STAR could work in conjunction with the GP's who prescribe methadone to provide the social and emotional development needed for individuals to stabilise and move into mainstream society.
			Detox safety and aftercare. We would encourage individuals to talk to their GP's regarding a timed detoxification. A block to individuals detoxification is if patients detox and relapse they would have to wait up to a year to get back onto a methadone programme. If the individual is well informed about the dangers of overdose and given ongoing aftercare they can detox safely.
5		SharingPoint	Reduced waiting times for methadone treatment needs to be a key area for immediate focus. If waiting time between decision to enter a programme and acceptance on to a programme is too long often the desire to stop using illegal drugs has passed and the opportunity lost.
			Methadone reduction. There is a need to review the policy and practice around reducing methadone dosage. The current practice of reducing methadone scripts for service users because of their illegal drug use needs to be balanced against the typical negative consequences such as - greater use of illegal drugs to avoid withdrawal, risk of overdose, and reduced ability to provide clean urine.

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7		CARP-Killinarden	Need for wider access to treatment. People in all parts of Ireland should be entitled to receive methadone treatment if they desire it and have the necessary underlying conditions. Need to ensure that people will receive treatment even if they are deemed to be difficult.
			Waiting times. Should take the National Drugs Strategy as a guide and have people in treatment within one month of presenting.
			Methadone should be one of a menu of options for people seeking help with heroin use.
			Value for money treatment. We need to decide what is value for money when looking at the different treatment options and who decides what is value for money. The cheapest form of methadone ok, but a regime that doesn't engage with clients and help them to turn their lives around - should that be the criterion?
			Prescribing and dispensing. We should explore the prescribing of methadone by others other than doctors. Methadone dispensing in local pharmacies should be done in such a way to respect the dignity and confidentiality of the patient.
			Treatment in Justice system. People in methadone treatment are entitled to the same treatment in prison as when outside of it. People on treatment in prison must be released as such a time so their treatment can continue uninterrupted. Possession of small amounts of heroin/methadone should not be regarded as a criminal offence.
			Heroin addiction should be regarded as a chronic and not acute condition. The protocol should be cognisant that people on methadone may also be using a cocktail of other drugs.
			More residential treatment places for mothers. More residential places must be provided for mothers during which they won't be separated from their children.
			Religious based residential treatment facilities must be included as part of the overall response to problematic heroin use.
			More respite facilities. More respite beds must be provided for people who need a temporary break from their drug use.
			Treatment cards extensions. The length of time a person's treatment card should be extended to 90 days for people who enter residential treatment.
			More residential detox beds must be provided throughout the county
			Rewards for service users. We should have a reward system for people in treatment.
8		Irish Pharmacy Union	Support for methadone in pharmacies. There is scope to expand the number of pharmacies participating in the methadone treatment scheme and pharmacists are interested in developing their role in the scheme, provided there is adequate support. Delivering methadone treatment through community pharmacies is not only beneficial for the patient, but it is also less conspicuous and more convenient for them to receive treatment from the local pharmacist than to travel to one of the methadone clinics. It has also been proven to be more cost-effective for the State. The people involved in providing this service need support. Financial support from the HSE afforded to pharmacists providing this service does not cover the extensive costs faced in providing this service, which is not the case at present.
			National Pharmacy Co-ordinator needed. Improvements to the methadone treatment scheme delivered through community pharmacies could be made via the appointment of a national pharmacy co-ordinator to oversee implementation of the scheme and to provide training and support to participating pharmacies. This person could provide assistance with addressing issues that arise for community pharmacists; such as unstable methadone patients presenting in a pharmacy and ensuring correct payment for takeaway doses of methadone is received.
9		Dun Laoghaire Rathdown Local Drugs Task Force	Relaxing restrictions on Level 1 and Level 2 GPs. A significant number of heroin addicts are suitable for treatment in a GP surgery, but at present most GPs in our area are treating the maximum number of patients allowance under the protocol regulations. Patient caps for both Level 1 and Level 2 should be increased and Level 2 GPs should be allowed to provide treatment from more than one location. This is within the ethos of treating people in their own local area.
			Social stigma. Some clients presenting to services are unwilling to attend larger methadone clinics in area due to the frequently expressed public perception that heroin addiction is shameful and because of negative public and family consequences, such as a fear of losing job if seen attending. Those in full time employment/education struggle to attend due to time constraints.

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10		Clondalkin Addiction Support Programme (CASP)	Limited access to detox beds. There are significant challenges for those who present looking for detox who are not on methadone treatment, as they may not even be considered until they have been stabilised on methadone. Willingness to explore, support and assist clients with detoxification in the community through GP prescribing services often lacking. Linkages with approved pre-entry and post-detox residential rehabilitation programmes not fluid and timely. People fearful, on completion of detox, that if they relapse they will have to go back on a waiting list; there should be a set period post detox where an individual's place is held. Range of options limited - reliance is on methadone, extending range of substances with focus on detox may decrease methadone culture.
			Stabilisation should be part of continuum of care. Access to short term residential service that could support individuals to stabilise on their treatment dose may be of value if viewed as part of the continuum of care, particularly for high risk groups (homeless, HIV+, HEP+, etc).
			Issue of polydrug use with methadone and associated risks needs to be looked at. Users highlight inconsistency of practice and expectations from GPs - users that are in receipt of similar treatment are dealt with in different ways.
			Waiting times. Waiting lists and access to places proves to be a continued problem, with access to supports and harm reduction services identified as crucial at this stage (6+ months in some cases).
			Methadone access in prisons. Concerns as to the effectiveness of systems in place in relation to those arrested and in prison was highlighted. Experience within service has highlighted the challenges in terms of clients being initially prescribed methadone and the process to ensure same occurs can at times break down and clients can be left waiting. In terms of harm reduction strategy this system needs to be resourced and adequately resourced. Given the high use of illicit substances in prison and the risk of infection.
			Monitoring and supervision of individuals on methadone within the community is varied. Inconsistency of practice and expectations from GPs reported and it can seem that drug users attending the same service or receiving similar treatment are dealt with in differing ways. Feelings that the level of expectation placed on those in treatment is determined by the GPs, especially in cases where individuals attending clinics/GP practices still engage with drug use.
			Rehabilitation depends on a range of supports. A process which supports and allows drug users to access a range of emotional/training/psychological/physical supports and build on the initial focus of stopping opiate use is of value and needs to continue to be made available and extended where not present. A particular focus on education/training without the attending psychological supports was named as a concern by staff who felt that viewing individuals in terms of work readiness and ability to comply with work requirements may not sufficiently address their needs in terms of relapse prevention, homelessness, on-going medical problems or indeed resilience to stress. The inclusion of the broader family system in the rehabilitation process was identified by groups in the service; as the impact of an individual moving from drug use to stabilisation and/or drug free status directly impacts on those who live with them.
11		Waterford Substance Misuse Service	Absence of services in parts of the Country. There is a huge increase in opiate IV users presenting to services in Waterford, with no methadone option available to them. Currently Level 2 GPs travel on a rotation basis from Dublin to provide a service, which is causing problems around continuity of care. There is need for a Waterford based Level 2 GP to provide services locally, integrated with the local Substance Misuse Service. There is little movement out of the Level 2 clinic resulting in waiting times of over 2 years for clients trying to access methadone treatment.
12	Dr Sean O Domhnaill		Open up the protocol to allow non-GPs with specialist training to treat opiate users who want treatment in the rural districts. Several Consultant Psychiatrists with special interests and experience in the treatment of opiate/opioid addiction and its treatment cannot be taken on by the protocol because they are not GPs. We do not have the luxury of a surplus of experts in this field who are willing to take on the duty of care for the clients in addiction.
13	Dr Hugh Gallagher		Countering service user feelings of isolation and sense of abandonment on transfer to methadone treatment protocol needed. Often this is due to being without the availability of counselling or association with rehabilitation agencies.
			Alternative treatments. Service users are requesting alternative treatments. The minimum that should be provided is that Buprenorphine be allowed to be prescribed on the protocol.
			Handbook detailing services for drug users should be made available, detailing rehabilitation programmes, stabilisation programmes and detox facilities.
			Level 1 and Level 2 GP patient caps should be increased to 20 at Level 1 and 45 at Level 2. This should be done in conjunction with a more robust audit.

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14	Dr Cathal O'Suilliobhain		Treatment for opiate users in Primary Care should be encouraged and expanded by the rationalisation of present regulations limiting practice. Evidence would suggest that treatment outcomes for a majority of patients are improved in a primary care setting as opposed to the "methadone clinic" where they must commune with large numbers of other drug users. By allowing a Level 2 trained GP to practice as part of a number of Primary Care Teams we could greatly increase the number of treatment places available in the country at a reduced cost and without the difficulties and expenses that occur when we try to open new treatment centres. This will also facilitate treatment in areas outside of our major cities where medical treatment for opiate addicts is now almost non existent.
			Increasing patient numbers for Level 1 and 2 GPs and allowing Level 2 GPs to practice from more than one location. When the Methadone Protocol Scheme was designed it was decided to limit the number of patients attending Level 1 GPs to 15 and level 2 GPs to 35. These were arbitrarily picked numbers with no foundation in evidence or even experience. All level 2 GPs I have spoken with can see no reason why they should be so limited and in fact a majority of them are over their numbers as they do not wish to refuse patients entry to treatment. All have agreed that treating 50 patients in their practice would not present any problem. I feel that these numbers could be safely increased and I see no reason why Level 2 trained GPs cannot provide services from a number of locations.
15		Southern Region Drugs Task Force	Opiate use should not be viewed at in isolation, but should be recognised alongside other substances in line with the new Substance Misuse Strategy.
16		Bray Local Drugs Task Force	Variety of locations for methadone treatment, such as from GPs and local addiction treatment centres, has provided choice for individuals and options regarding rehabilitation and fulfilment of responsibilities (parenting, work) while receiving treatment.
			Benefits of satellite clinics. These provide opportunities for individuals to receive methadone treatment in their own community, enhancing their support structures for rehabilitation. Generally operating in the evenings, these clinics also allow individuals to take up employment during the day. The presence of satellite clinics in the community has also ensured community support and a sense of ownership for treatment and rehabilitation of drug users, as well as reducing the risk of marginalisation of drug users in their communities.
			Regular attendance during treatment, particularly at the beginning, provides structure and a sense of purpose for individuals. Support received from contact with other professionals such as nurses, pharmacists, counsellors, GAs, CWOs, ensures that the individual will receive support to begin to address other aspects of their lifestyle: health, family, finances etc, which their addiction problem has had a negative impact on.
			Establishment of care planning for individuals attending methadone treatment. If successful rehabilitation is to occur the care plan must include a plan for all aspects of the individual's life and to include all service providers involved - statutory, community and voluntary.
			Assigning individuals attending for treatment to a team with roles and expectations clearly defined to the individual.
			Lifting GP patient caps. While certain restrictions are necessary doctors with experience of dealing with drug users should have their patient numbers reviewed on a case by case basis.
			Emergency access to treatment for people receiving methadone treatment in certain circumstances - such as release from prison or hospital, being arrested or detained in a Garda station.
			Dual Diagnosis service development is essential. There remains ambiguity with regard to methadone provision and treatment in the event of individuals also needing psychiatric care.
			Development of service for under 18's. There are circumstances when these individuals need to access treatment however adult services are not appropriate. The youth work model of working should be incorporated into treatment services for under 18's.
17		OMD	Interagency working and a continuum of care would be welcomed where the provision of methadone with active consideration of stabilisation of clients and progression towards detox from methadone and rehabilitation are all linked in.

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18		Northern Area Voluntary Cluster and Dublin North Inner City Drugs Task Force (submissions received separately, merged here due to crossover of themes)	Reduction of waiting times. The KPI for methadone waiting lists is not being met. Within the Dublin Central area this is particularly relevant in relation to Trinity Court/NDTC which services frequently report waits up to 4 months . When working with chaotic users by the time the place for treatment becomes available then there may be no motivation to avail of the treatment option. Reduced waiting times for methadone are a priority for service development.
			Clear pathways for detox and stabilisation. Standards should be developed for all methadone prescribers. This should include all doctors having a clear outline for the process to be undertaken for detox and stabilisation. In no case should requests for detoxification be refused without a clear pathway being outlined and appropriate supports being referred to. Standards should be agreed across services and GP co-ordinators should be tasked with ensuring that all GPs are aware of these requirements. Any complaints in this regard should be dealt with by the GP co-ordinator.
			Extension of community detox options. The community detox protocols have shown that co-ordination between clinical and GP services and the community and voluntary drugs services can be effective in providing non-residential detoxification services. These protocols should be either be extended and then formally evaluated or formally extended to other HSE / Task Force areas.
			Review methadone reduction policy. A number of service users have had their methadone scripts reduced due to their illegal drug use. While the overdose dangers of illegal drug and methadone use are acknowledged, there should be a review of policies regarding weighing up the risks of overdose against the continued risk of use of non prescribed drugs while on a clinic.
			Removal of sanctions that reduce methadone maintenance. Other non-punitive practices should be introduced to assist with behavioural management. Each clinic should have an active inclusion policy which identifies how it will manage behavioural difficulties while maintaining appropriate levels of service.
			Utilisation of positive re-enforcement / contingency management as an innovative and creative approach to rehabilitation in clinics and voluntary providers.
			Clear and transparent guidelines for transfer of service users to GPs. Service users report requesting transfers but having no reasons given for denial of their request. Clear guidance on the process would allow for more effective care planning and key worker supports for service users who wish to work towards transfer into the community.
			Review of benzodiazepines as barrier to GP transfer. In some clinics it is reported that service users must be free from benzodiazepines prior to transfer to a GP - standards should be clarified and reviewed and guidelines made widely available to facilitate interagency care planning.
			Clear guidance on takeaway prescribing is needed and should facilitate flexibility from the doctor's perspective. Pharmacists need to consult with the GP around any prescribing decision.
			Regular reviews for all service users receiving methadone maintenance. Service users should be asked if they are happy with their existing situation or whether they would like to detox, reduce methadone or whether they require stabilisation - this should be recorded on file. Well managed reviews can provide opportunity for care planning. Staff should be trained in brief intervention/motivational interviewing,
			Provision of suboxone and subutex. There should be a range of options on offer and clear prescribing guidelines should be made widely available to medical and non-medical services.
			A heroin pilot should be considered an Irish context. Trials from the UK have had sufficient results to substantiate a trail within the Irish context in relation to long term chaotic users.
			Nurse prescribing. Protocols should be adapted to allow nursing staff to prescribe methadone in order to increase access in suitable locations.
			Reduce community clinic residential requirement to 3 months. Clinics have different requirements for how long an individual has to be in the area prior to being able to access a local clinic. In all cases the residential requirements should be reduced to 3 months to assist with the management of waiting lists and encourage treatment in the community.
			Opening hours should be extended to evenings. This would facilitate groups like sex workers to access services more easily. It would also provide better options for day time activities like employment and courses. While there is guidance that individuals should be facilitated to receive early morning prescribing to facilitate attendance at university or college, this is not always happening. Clear guidance should be provided to all prescribing doctors on this and the appeals process should be established to manage non-compliance from medical practitioners.
			Medical card fast tracking should be facilitated for all drug treatment service users to ensure that primary health care is being provided in the appropriate setting.
19		Rialto Rights in Action	Lack of real choice for treatment options. The experience is that there is no real choice when a person presents for treatment. One may be offered all sorts of options but the only real one that exists is methadone and it was never intended as a treatment option in the first place. The lack of real choice in practice to alternative treatment is a violation of the right to health and should be addressed as a matter of urgency,

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20		Traveller Specific Drugs Initiative, Pavee Point Travellers Centre	Reduction of waiting times for methadone are a priority for service development. The KPI for methadone waiting lists is not being met. In Dublin Central waiting times can be 4-6months. Many Travellers will seek treatment outside of the local area as a result of not wanting their families to find out - anonymity and confidentiality are of utmost importance to Travellers, with many travelling to Dublin for their methadone. Lengthy waiting list create another barrier to treatment once this decision is made.
			Reduction in length of local residency prior to access to drug treatment. The length of time a person needs to be residing in an area prior to being eligible for drug treatment should be reduced to three months across the board. Currently, this restriction varies from clinic to clinic but can be up to six months in some areas.
			Extension of community detoxification protocols. Providing community detox as an option for service users nationwide would suit members of the Traveller community as it is an option that can maintain the service user's anonymity and confidentiality. Some Travellers are reluctant to begin a methadone treatment programme as they feel they will be on it for too long so continue with chaotic drug use. The extension of these protocols would be a step towards eliminating this barrier.
			Transfer of service users from clinic to GP. For anonymity reasons, Travellers may prefer not to have their methadone treatment prescribed by their family GP, even it they are a Level 1 or 2 GP. Travellers requesting a transfer from clinic to GP should be given the option of GP to be transferred to,
			Clear guidance on takeaways. Clarity on take away prescribing in relation to service user holidays or exceptional circumstances needs to be widely disseminated. Showing respect to immediate and extended families plays a strong role in Traveller culture so attendance at family occasions is seen as highly important. These occasions may interfere with dispensing arrangements and the development of takeaway prescribing protocols should take this information into consideration.
			Regular reviews for all service users receiving methadone maintenance to ensure they are happy with their current dosage. Any requests to alter dosage, detox or stabilise should be recorded on their file. Service users need to see that methadone can be a short term option. The length of time some service users are on methadone can act as a deterrent for those contemplating treatment, especially Travellers. Regular reviews would counteract this feeling of being stagnant.
			Provision of Suboxone and Subutex. The range of treatment medication on offer should be extended, alternative treatment options to methadone would play a role in eliminating the barriers to treatment for members of the Traveller community.
22		Crosscare Drug and Alcohol Programme	Difficulty in being allowed to reduce the dose of methadone. Clients who were seeking to reduce their methadone dose have complained that they were limited to a reduction of 10mls per month, while they wanted a more rapid detox.
			Lack of alternatives to methadone for people with Codeine dependence.
			Difficulty accessing a detox bed for a client who is NOT on methadone. For people wanting to detox from heroin, waiting times can be unacceptably long.
			Lack of Detox beds. From participation in National and International committees we are aware that the number of detox beds in Ireland falls far short of the recommended target.
23	Deirdre Carmody, Drug Liaison Midwife		The Drug Service prioritises pregnant women with heroin addiction onto a methadone programme without making similar arrangements for their partners. Research has found that partners, who are not prioritised onto a methadone treatment programme and put on waiting list, can influence pregnant women to continue using heroin.
			Access to services. We are having difficulties with pregnant women using heroin looking for treatment in areas outside methadone treatment areas such as Kildare, Newbridge, Celbridge and Enfield. The only methadone treatment we could offer them was The Drug Treatment Centre Board, Trinity Court, City Centre which some women found to far to travel to.
25	Dr Fidelma Savage		GP patient caps a barrier to treatment. I practice in North Wicklow and since I reached my limit of 35 patients in about '02 I have been able to accept few new patients. I think that the numbers of patients I have been unable to treat is at least 1 patient a month. At present, for those who live outside the town boundaries of Arklow and Bray the only other route into treatment is via the Drug Treatment Board's Centre in Dublin. Very few people have been willing or able to travel so far daily to access treatment. I understand that a review of the protocol in '03 recommended increasing the number of patients to those who were audited. I have been audited since then but have had no reply to my requests to relax this restriction. I would urge you to consider relaxing the restriction on my practice in order to allow me to address this clear unmet need in my community.

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26		SAOL Project	Waiting lists. The KPIs for methadone waiting lists are not being met. A full review of service capacity needs to be held to see the extent of under capacity the system currently has. Service users report high levels of risky drug practices as a result of no treatment, lost opportunities for those who were once motivated to seek treatment and depression and disillusionment amongst their peers.
			Review of reliance on methadone as the primary opiate replacement in this country with a view to extending the protocol to include making available all opiate substitutes in drug treatment centres. Initial assessment to include rationale for selecting the particular opiate substitute and this information to be available to the client as a starting point on their care plan.
			Methadone reduction policies. Clients report that methadone sanctions are used if they miss giving two urines. If this situation exists there needs to be an urgent review of this policy and this should include looking at the impact of this on service users as well as seeking to explore other methods of encouraging compliance, such as a reward process.
			Access to methadone outside of normal dispensing routines. This issue comes up time and time again over the years. As things stand, there is no provision for dispensing methadone to a client if, for example, they are too sick to attend their clinic or pharmacy. The system has no flexibility and we ask that consideration be given to circumstances where a client cannot get to their clinic for genuine reasons and to look at possible alternatives – either through a nominated other individual that is acceptable to both parties or an outreach programme if necessary.
			Complaints and appeals. There is a need to implement a system where clients feel they have re-dress in situations where they currently feel powerless. Several years ago a complaints procedure was initially promoted within drug treatment centres but has lapsed completely at this stage.
			Clients are not being listened to when they ask to detox. Some clients have made several requests for detox but are repeatedly told by doctors that they weren't ready - this reinforces the belief among service users that they are not being listened to, de-motivates them and prevents them from raising the subject again for a long time. Clients who are more determined to detox end up doing so in secret, often with poor results and more chaos down the road and increases the risk of methadone street diversion or client overdose.
			Community detox options not being promoted. Clients are not made aware through their drug treatment centres about the options available for community detox and the protocols for community detox are not being promoted vigorously by drug services. Every client should be made aware of the detox process and what is required from them and their treatment service. The standards do exist but they are not being implemented.
27	Dr John Moloney		Weekend dispensing. The methadone protocol should support the provision of supervised seven-day dispensing in all treatment centres to chaotic and new patients in a setting which can manage the issues which these patients preset at the weekend and which can be resolved by medical staff who know them.
			Services for special needs groups. Suicide, Hep C & Alcohol, Children of methadone patients. (Suicide) The "Assist Programme" should be made available in all centres in association with the National Office of Suicide Prevention. (Hep C & Alcohol) The Fibroscan Programme in the former East Coast Area should be made widely available within the Addiction service and shared care programmes with the local Liver Units to deliver treatment for Hep C patients; Alcohol dependent patients who are stable on methadone need greater access to alcohol programmes, while remaining on methadone; Closer clinical links with the Liver Units. (Children) Multi-agency approach to children of patients should be developed further; Parent Support Liaison Nurse Post should be mainstreamed
			Maximising treatment provision geographically. Medical and physical resources of Addiction service could be an asset in expanding geographical availability of services.
28		Tabor Lodge	Range of treatment options not being offered. 1993 Protocol establishment report recommendation that "following assessment the individual should be offered a range of options including detoxification, support for a drug-free life, referral to a programme of rehabilitation or methadone maintenance programme" is not being fully implemented and by default a methadone programme becomes the treatment for the majority of people. This prohibits people exiting treatment having achieved a programme a rehabilitation
			Local access to a range of treatments limited. 1997 Irish College of General Practitioners report recommendation that "There must be local access to a range of services needed to assess, treat and follow opiate dependent patients" - concern that the range of services is quite limited and that patients do not have the option of pursuing extensive rehabilitation programmes. The treatment pathway using methadone stabilisation with the intention that there be progress to a comprehensive treatment plan, which includes detoxification and rehabilitation with the eventual goal of a drug free lifestyle, should be emphasised.

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29		HSE Addiction Services Dublin North Central and Dublin North	Service user-centred care planning. The service user, their needs and care plans should be central to the review of the protocol. Treatment options need to be outlined and explained to the service user. At induction service users should be commenced on defined programmes: i.e. stabilisation, methadone maintenance, detoxification. Care plans are essential with regular 6 monthly reviews and referral to other services and supports as required. Focus of drug treatment in primary care needs to be around rehabilitation, integration, facilitation and recovery.
			Variability in service provision outside Greater Dublin area puts pressure on local services that do not the sufficient development of substitute prescribing at secondary or tertiary level, this deficit in HSE clinics in regional services needs to be addressed urgently.
			Incentives required for Community GPs to support detoxification in Primary Care. Development of primary care teams between Level 1 and Level 2 GPs in an area to support discussion of cases. GPs need to be aware of service in the local community that are available to the service user and support referral to them.
			GPs need knowledge of detoxification protocols and the supports required to help he service user prepare for detox, during detox and supports required in aftercare.
			Transfer of clients from Level 2 to Level 1 GPs
			Increase access and availability of beds for detox in in-patient units and the supports required for aftercare.
			Structures for sharing of information and knowledge between medical and rehabilitation perspectives. The Addiction Services care plan needs to be integrated into the overall care plan of the client as per the NDRIC plan. This would then be co-ordinated by the overall case manager, regardless of whether they are located in the community of addiction services.
30		Soilse - Service Users	Waiting times. Waiting to access clinics for methadone treatment can vary from area to area - for example 3-9 months. There should be a time limit on waiting lists no matter where accessing treatment. When pregnant go on immediately,
			Detox should be offered over maintenance. Maintenance should only be offered as a last resort - people should be offered a 12-week detox programme at first point of accessing treatment.
			Greater treatment options. There should be more treatment options than just methadone, prescribed heroin should be a treatment option in Ireland. Also consumption houses should be made available to active users.
			There should be more information made available around recovery.
			Stigma in pharmacies. People labelled in chemist's, treated differently and no privacy
			Key working. Should be assigned key workers when accessing treatment in a clinic (not just general assistant and doctor).
			More detox beds needed and waiting lists abolished.
			Integrated care package. There needs to be a seamless transition from detox to rehab to day programme.
			Stabilisation options - unclear what they are
			Greater understanding needed of the long term effects of addiction; impact on families and children
			Mother and child facilities urgently needed
			Emergency care and intervention teams needed
31		SOILSE - Staff	There should be a paradigm shift from methadone treatment to rehabilitation. Soilse attests the paradigm shift in favour of rehabilitation will maximise provision of methadone treatment through stabilisation, detox and rehabilitation. Methodological clarity is key characteristic of a good service. It must be stressed that those accessing methadone treatment are vulnerable, often isolated, demotivated, with little social capital. They generally have poor literacy attainment and few personal and social skills so it would be wrong to assume they know about all or any aspects of their treatment or progression options.
			There should be an increase in detoxification and residential beds (Corrigan / O'Gorman – 2007). Evidence internationally heavily favours residential detoxification and this is the Soilse experience. Accessing more residential treatment beds is also a priority for seamless progression. Only about 1,200 "rehabilitation" daytime rehabilitation places exist for 10,000 plus on methadone, a ratio of 1 to 8 per annum. Consequently the overwhelming majority of drug users cannot avail of rehabilitation services.
			Treatment evidence base needs development. The evidence base on methadone is generally imported into Ireland. Figures for the dispensing of methadone in Ireland should be published per person and accrued as per average time on maintenance. Correspondingly there is an absence of evidence on what developmental options service users have taken up in Ireland since 1992 and where they have gone. Therefore the public and service users often consider methadone to be a cul-de-sac.

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32		County Wicklow Community Addiction Services	Continuous and consistent inaccessibility of clients to level 2 GPs in the region is impacting negatively on individual care plans
			Waiting times are unacceptable for an appointment with a GP.
			Clients are having to travel to Trinity Court often from rural isolated areas, several times weekly which leaves them more vulnerable to further substance misuse in urban areas.
			GPs are available and wiling to come and work in this vicinity but are restricted from doing so by limitations on their practices. This should be examined.
			Treatment in the community by community professionals of community citizens is a proven means of recovery with positive and constructive results.
			Travellers and foreign nationals who are disenfranchised and isolated often turn drug misuse. Frequently their inability to commit to a care plan is reinforced by the perceived drama attached to methadone accessibility. Traveller men in particular are presenting with problematic alcohol and opiate use.
33	Dr Colm Quinn		Benzos and opiate addiction. Many years ago the Department of Health issued a nationwide guideline to Community GP's about the special precautions/contraindications of prescribing benzodiazepines to opiate addicts. There cannot be any treatment centre doctor who is not concerned or frustrated by having their patients being prescribed benzodiazepines inappropriately (and often in monthly dispensing). In very many cases benzodiazepine abuse is often a greater clinical problem than opiate usage.
			Large clinics vs. community pharmacy dispensing. I think in hindsight we got it wrong by having so many patients dispensed in treatment centres. From my Waterford experience (Pharmacy only) I realise the vast majority of patients are Community Pharmacy acceptable. I think it is less pathologising and more normalising way of treating opiate addiction. I think clinic dispensing often results in contamination, dealing and regressive behaviour.
34		McGarry House	Information sharing. Clearer communication and sharing of information with all front line workers and key workers directly involved with clients referred for the programme. Better guidelines and understanding of care planning, confidentiality agreements, disclosure of information is required to benefit both clients and workers.
			A more holistic and standardised approach is needed regarding referral, assessment, care planning and treatment of those identified as in need of the programme.
			Structured plans for individuals regarding treatment and rehabilitation whether that be residential, day treatment of counselling. More emphasis on regular reviews and case conferences for clients, particularly those deemed more chaotic or vulnerable, e.g. in homeless services.
35	Dr Paul Quigley	Addiction Service HSE Dublin North East	Problems of treatment access and service quality outside Dublin. There are a growing number of treatment applicants where HSE clinics have not been developed. Without local clinics there is no flow of experienced prescribers to take cases into the general practice setting. The ICGP led 'protocol' prescribing is incapable of meeting the need that is there and the ICGP seems unwilling to own and monitor the work of the Substance Misuse Directorate.
			Problems of access for homeless or transient clients. The current arrangements for serving this group do not work. Trinity Court is overloaded and cannot carry out its remit for homeless applicants. The Safetynet service represents a way forward and ought to have had more support. That model could be a potential for dealing with prescribing for persons in custody.
			Retention and progression. Adequate dosing, with no sanctions for illicit drug use other than restrictions of takeaways, has been effective in delivering a very high retention rate. Maintenance of decent order, with thoughtful examination of incidents and challenging behaviour, is critical to establishing trust. Temporary transfer rather than barring allows clients the opportunity to reflect and return without interruption of treatment. Supervised dosing is very well tolerated, provided clients are not kept waiting and the ambience is generally positive.
			The worlds of rehab and treatment need to interact much more closely. Given the chronicity of the initial caseload and the delay in introducing the MMT in Dublin, progress in stabilisation of addiction has been slow. Question whether key decision makers grasp the situated nature of our opiate and multisubstance addiction problems.

Sub. ID	Source if individual	Organisation	Submission
36		Dublin North East Drugs Task Force	Holistic approach to treatment requires consideration as to how multidisciplinary/interagency groups engage and communicate with the clinical team, so that the community may be informative and supportive of the clinical work and vice versa.
			Care planning and case management are essential and there is a need to standardise protocols through all services.
			Sense of disempowerment among some clients an issue. The treatment process is more effective when clients have a sense of ownership of their recovery and understand the process of methadone reduction and increase. Clients encounter this problem when they feel ready to move one to the next stage and the doctor may not and being told "what it right for them" rather than having a say.
			Limited supports for people who have reached total abstinence. Service users have expressed an issue with regard to maintaining recovery.
			Involvement of families of drug user's in care planning where possible.
			Methadone treatment should be temporary or time limited (though in some cases long-term) and strengthened by psychosocial courses to aid the client in their recovery and promote healthy outcomes. A methadone programme should strengthen motivation by providing a non-punitive environment within which self-help and peer-help can operate to alter life style. New ways of addressing and exploring methadone maintenance medical alternatives should be a priority.
			Accurate information on methadone, its affects and keeping healthy when stabilising and reducing methadone is needed.
37	Dr Declan O'Brien & Dr Don Coffey		Travel for patients who live outside of Dublin. The Protocol as first developed was to combat a Dublin problem. As such it works well in an urban situation. However the situation is very different outside of Dublin. We are regularly dealing with clients/patients who have to travel over 100km to see a doctor and maybe a third of that distance to get a community pharmacy.
39		Safetynet Primary Care Network	Specialised services for homeless. Homeless people have expressed a clear preference for having specialised-services over mainstream-services. The use of specialised-services located at points of contact with homeless people (e.g. hostels, food hall or drop in centre) has been shown to improve access to health-care and decrease the burden on secondary-care services. Safetynet has piloted in co-operation with Central Treatment Services a very successful specialised service for delivering methadone maintenance to homeless people. It has been a good example of co-operation between the commuunity GP sector and Central Treatment Services. This programme is audited by the HSE/ICGP methadone audit committee and was successfully accredited in March 2010. We propose that the programme be recognised as an integral component of the treatment of drug addiction in the homeless sector. We further propose that all Supported Temporary Accommodations in the new Reconfiguration of Homeless Services have such specialised methadone treatment services.
40		Irish Medical Organisation	It is vital, given the limited resources available to ensure that any treatments provided are evidence-based and appropriate to the individual patient at that time.
			While Methadone Clinics provide an excellent service, they can be difficult to establish due to resistance from the community in which they are to be set up. As such the cost effective approach of providing treatment in a general practice setting is an effective arrangement which should be expanded, particularly given the current economic climate. Given the obvious need to made treatment more accessible and in some areas, to provide any treatment, we recommend the expansion of this successful scheme to provide methadone to drug users in all parts of the country.
			Support for GPs treating drug users in the practices. Patients treated in general practice may not have the same access to supports such as rehabilitation and counselling which have traditionally been clinic based. The IMO welcomes the proposed rehabilitation pilot programmes to facilitate integrated rehabilitation and support networks in the community and urge the review to support such measures. Support for GPs treating heroin users including the Practice Nurse and allowances for study leave were agreed in the contract in 2003, despite numerous attempts to address this issue by the IMO, these supports have never been provided as agreed.

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41		FSN	Involvement of the family in methadone maintenance treatment should be encouraged, welcomed and supported. Family members still feel alienated from the treatment services including methadone maintenance treatment.
			Information. In order for families to act as agents of recovery they need access to information on methadone. Families need know the physical, psychological and emotional effects of methadone maintenance.
			Availability and quality of service. Family members living in rural areas are frustrated with the lack of methadone facilities and treatment providers. Family members living in better serviced, more urban areas, believe that there is an insufficient number of clinics or staff to deliver a quality treatment service and feel that this understaffing or under resourcing leads to poorer treatment outcomes. There should be more choice with regard to treatment options other than methadone maintenance.
			Reduction of waiting lists. Waiting lists for assessment for methadone maintenance treatment and a place for treatment are too long. Often by the time the place for treatment becomes available their loved one may no longer be motivated for the treatment option.
			Clear pathways for detox, stabilisation and rehabilitation. Some users are not encouraged and at time discouraged to detox, with little explanation and no attempt to develop a plan to set this as a future goal. For those on low doses a structured support system should be in place to assist them to make the transition to being drug free. There is a need for more detox beds and a reduction in waiting times to enter detox. and a need for more rehab facilities for those who have detoxed. Community detox services should be expanded.
			Review of methadone reduction policies. Reducing scripts due to illegal drug use counterproductive and leads to service users using heroin to avoid withdrawal.
			Removal of sanctions that reduce methadone maintenance. If methadone has been endorsed as a medical and state sponsored response to heroin use than there can be no non-medical situation which would warrant the reduction in the amount of methadone prescribed.
			Regular service user reviews. There should be a plan in place for each service user that focuses on specific goals and targets. Methadone maintenance programmes should have closer monitoring and evaluation
			Opening hours. Extension of clinic opening hours to facilitate lone parents and the return to employment and training
			Treatment in prison. All prisons should have to prescribe methadone to individuals who are in need of the service. There should be a greater continuity of care for drug users leaving prison.
			High turnover of staff in clinics, especially counsellors. Families feel this impacts negatively on drug users
43		Ballyfermot Advance	Detox should be decided and negotiated between the doctor and the client - clients feel it is not the best option for everyone. The client should not be denied detox or told they are not ready, they should be allowed to try. There is a need for more detox beds and the lead in to inpatient detox should be less than six months. Community detox programmes need to be expanded to include people who cannot enter residential programmes. There should be shorter detox options made available - Lofexidene for example. There should be opportunity for clients to participate on a partnership basis in a fully supported detox programme - long-term methadone maintenance cannot be the only option. Clients feel they should not be put back on to a waiting list if detox attempts fail, they should be given options and informed of choices, such as drug free options.
			Other treatment options. There is a lack of treatment options in Ballyfermot and unwillingness of the authorities to adopt a more progressive rather than conservative approach to treatment. Options such as Suboxone, Subutex, Lofexidene, Naloxine, LAAM are rarely if ever offered to clients. Clients feel there should be options; if they don't want methadone there is no other choice.
			Universal availability of treatment. It is unacceptable that some areas have waiting lists for treatment, whilst others have little or no waiting period. Capacity should be made available where it exists.
			Stabilisation. Opportunity for stabilisation must be encouraged on a regular basis with review of urinalysis between doctor, key worker and client. Inpatient stabilisation programmes must be made available with shorter waiting times for beds. Harm reduction and reduced dose needs to be broadened in terms of alcohol intake. Client opinion is that reducing dosage in the clinic only drives clients to drink more alcohol or take heroin. The amount of other drugs, such as valium, antidepressants etc, given in conjunction with methadone must be reviewed. Librium detox should be offered to clients drinking whilst on methadone - and alcohol support programmes could be offered on a daily basis within the clinic setting. Clients feel that stabilisation should be evaluated with them every month, so they feel valued.
			Rehabilitation must include open communication between the community and voluntary sector who play a very important role in the ongoing and long-term rehabilitation of the person. Case conferencing with voluntary and statutory agencies must become best practice and family involvement should be considered. The mental health services and the addiction services much work more closely together to prevent dual-diagnosis clients falling into a grey area where there is a lack of care. Every client must have a care plan and care planner.
			Clients say that that methadone doses over 90ml a day are wrong; measurements have gone up over the years, people first thought they would get by on a lower dose, but the numbers have crept up. Methadone treatment should be time limited and should only be supplied when compulsory treatment is also offered.
			The mental health services and the addiction services much work more closely together to prevent dual-diagnosis clients falling into a grey area where there is a lack of care. Every client must have a care plan and care planner.

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44		Clondalkin Local Drugs Task Force	Medical model and holistic model. Services - statutory, voluntary and community, need to implement a process that will enable practitioners to correctly monitor and implement a therapeutic methadone treatment programme with the correct doses to enable patients to lead a "normal" life.
			Alternatives to methadone treatment e.g. Lofexidine and Buprenorphine should be explored at the starting point for rehabilitation leading to detox and drug-free, as oppose to creating life-long dependence.
			Retention period for methadone stabilisation. A time scale of 2-3 years has been identified as an acceptable retention period for methadone stabilisation providing resources re continuum of rehabilitation are available. For some individuals a lesser time scale may be appropriate.
			More consultation between doctors/clinics, patients, family and community workers to create an inclusive care plan
			Inclusion of family in the overall rehabilitation process as it is acknowledged by clients that their family can play a significant supportive role in their recovery process.
			Longer timescales for detox programmes and access to more beds
			Provision of more holistic aftercare services including mental, emotional, spiritual, physical, recreational and education.
			Provision of safe respite for homeless, HIV, HepC patients
			More treatment options and residential places for single parents with children and families.
45		GPSSA Education Committee	GP patient caps. Review of the cap on the number of patients Level 1 and Level 2 trained GPs can treat in general practice.
46		Drug Treatment Centre Board	Need for greater provision of services outside Dublin with local implementation by GPs supported by clinics and voluntary agencies. We suggest that suitably trained local GP's carry out that function supported by GP Co-ordinators through the primary care network. In the interim consideration should be given to the numbers of patients level 1 and level 2 GPs and pharmacies can treat as well as the geographical boundaries currently in place.
			There is a need to provide consistency in the standard of care countrywide. National standards supported by clear protocols need to be developed with regard to what services will be provided, e.g. stabilisation - how they will be provided, by whom and what the patient can expect (from a patient point of view) and what services doctors can expect.
47		Ballymun Local Drugs Task Force	A range of methadone modalities (reduction and maintenance) and other alternatives to be communicated, encouraged and available to all clients including the nature of community supports available in a client's area
			Responding to service user needs. Feedback from clients in relation to methadone provision include: length of time on methadone, resistance towards coming down from doctors, difficulty with the transition from low doses to methadone free, quality of certain services, lack of encouragement and confusion between key worker and counsellor.
			Difficulties for clients in the system, including: sole responsibility given to GP, lack of consistency, limited key working, limited opportunities for clients to participate in programme design and delivery, difficulties around dialogue and communication between agencies (statutory and voluntary) and clinical meetings only referring to those in crises.
			Limited joined-up working between sectors with, in some cases, conflicting policies and approaches for clients with co-occurring drug/alcohol and psychiatric issues. For this group methadone treatment needs to be responsive, flexible and appropriate to their presenting circumstances.
			Treatment/care plans should be drawn up when a client presents for methadone with a beginning and detailed review periods scheduled and undertaken as part of that persons treatment programme.
			Community detox models should be further explored in local areas as a formalised way of progressing clients through the methadone system whereby statutory agencies fully participate and engage with the process.
			Need for engagement in programmes around the building of life skills and encouragement of other supportive elements at all stages from those contemplating methadone use to those who relapse and those who become drug free from methadone.
			Encourage drafting and dissemination of appropriate working documents/protocols in areas related to methadone provision, e.g. ICGP protocol for methadone use in Garda stations; community detox; and benzodiazepine reduction/detox etc.
			Developing the role of pharmacies in methadone provision. Pharmacies are often one of the main sources of regular contact for clients and do locally provide a level of support for clients that could be further enhanced.
			Developing nurse prescribing services in clinics/areas outside of the city centre as has been launched by the Drug Treatment Centre Board.

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48		Kilbarrack Coast Community Programme	Clients views on methadone reduction and detox were that it is harder to come off methadone than heroin, and that they are not listened to, and sometimes ignored, by doctors when wishing to reduce their methadone use. The majority felt they would be on methadone for a long times and some felt trapped by it.
			Clients views on treatment when entering/leaving prison. Practical problems of being on methadone then going into prison and having to wait a number of weeks before getting it, or when leaving prison having been on methadone and having to try and find a clinic that would give you a script.
			Staff views on methadone treatment duration was that being on methadone for a short or time-specific period gave the opportunity to the drug user to emerge from the chaos and to repair close relationships.
			Staff views on the relationship between clients and service providers. Current system places the client in an unequal power relationship. If the client speaks out then she or he jeopardises their methadone supply.
			Staff view on the role of methadone - overall there was a feeling that methadone should play a role in rehabilitation but the current system over relied on it and has lost sight of the client and contributed to the client being dis-empowered. Methadone should not be the only or primary treatment and drug treatment should be more than a methadone delivery service.
			A more individualised treatment focus needed. We would like to see: the addition of dual diagnosis workers in either the HSE or the community/voluntary sector; the HSE adoption of a key worker and rehabilitation manager system with parallel developments in the community/voluntary sector. A bigger emphasis on moving people on.
			There is a need for the necessary detoxification and stabilisation beds to be put in place
			Implementation of HSE policies and procedures. There are excellent policies in the area of addiction, including the continuum of care model, case management, care planning, inter-agency working and rehabilitation strategies. But on the ground their implementation has been patchy and in some cases non-existent.
49	Dr Desmond Crowley		Waiting times. An urgent review of services that have waiting times of over one month needs to occur; e.g. Trinity Court and many of the services outside of Dublin. I wonder about the validity of waiting lists that are 6-12 month waiting times and whether there is any real validation of these waiting lists.
			Care management and planning. The inconsistent role out of care planning has reduced the through put in our services. We have been over reliant on medical staff in providing drug treatment, and I feel it is timely to involve others in the ongoing management and care planning. There is a lot of capacity for care planning and key working with non statutory agencies. The QUADS initiative along with the development of interagency working protocols will assist this process e.g. IAP in Blanchardstown. It is important at initiation into treatment that a comprehensive care plan be developed on each patient and that a clearly defined key worker is identified.
			Needle exchange & outreach. The role of the outreach in our service needs review. In my experience working across a lot of different services and locations the majority of IV drug users get their needle exchange from the Merchant's Quay project. They are located in a central location and are open all day, five days a week. Our services are once weekly and for short periods. I would like to see this role changed to a key worker role key; worker care planning the particularly vulnerable and the homeless and the poor attendee's and noncompliant service users. Along side this we should look at pharmacy needle exchange.
			The counselling discipline has continued to work a model which in my opinion is not maximising resources. 80% do not access counselling and in some centres there is a no show rate of over 60%. The service still insists on issuing hourly appointments to patients and have not looked at offering a range of options including shorter appointments with an emphasis on brief intervention.
			Review role of general assistants. This group of staff is very involved with our patient group. They are often the first staff member that patients turn to with their problems. It is my view that we should up skill the role a to clinical one which should include a key worker role and this would fit nicely with a reduction in their role in direct supervision of urine samples.
			Review and define role of Trinity Court. It is my view that this service is failing in its remit of looking after the homeless and the dual diagnosis. It is very well funded and fails to deliver appropriately. A lot of frustration exists arising from the lack of clarity about role, policies, processes, which are non-transparent.

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50		Consultants in Substance Misuse	Comprehensive Care Plan. To enable appropriate intervention at this level will require a comprehensive assessment and care plan reviewed on a six monthly basis for all patients on methadone treatment This includes appropriate management in relation to the issue of polysubstance misuse including alcohol.
			Interagency awareness and engagement. To move a patient through the process of detoxification and rehabilitation will require the prescriber to be aware of the community rehabilitation options and engage with a wide range of services both in the statutory and voluntary sector. A forum whereby primary care and other agencies could link and discuss the issues of interagency working would be of benefit.
			Primary Care role. Consideration should be given to the provision of training in relation to Brief Interventions at Primary Care level. In addition the use of Liaison Nurses to operate between Primary Care and other services would be of benefit and this staff grade could help identify and motivate patients towards detoxification.
			Expansion of service locally. On a national level we consider that the development of local substance misuse services under the direction of a consultant psychiatrist in substance misuse would further expand the numbers of practitioners willing to become involved in the provision of methadone treatment. The back up, support and governance structures provided by such a service would allow many more patients to avail of this treatment and the latest figures in relation to opiate use outside the Dublin area indicate that this is a growing problem.
			Support for patients who destabilise. A patient who destabilises during this process may need the support of a more structured substance misuse service and this could be facilitated through a network of HSE Substance Misuse services via the GP Coordinator
			Liaison pharmacists. We consider that the area of pharmacy and the role of the liaison pharmacist need to be also examined as these are both critical in the development of methadone treatment nationally. The pharmacist should be subject to training, audit and governance in the same way as the GP.
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Maximising treatment through more GPs and Pharmacists. We believe that maximising the number of treatment places is better served by increasing the number of GPs and pharmacists who offer treatment than by increasing the number of patients who attend each pharmacy/GP practice. Increasing numbers in one location may impact on the quality of treatment offered by the GP/Community Pharmacy. Large numbers of patients being treated at one location has been shown to cause social and community problems. GP Co-ordinators, local Drug Co-ordinators and Chief/Liaison Pharmacists must be encouraged to increase their contact with community services in order to recruit new GPs and pharmacists and maximise treatment places.
			Consideration should be given to expanding the role of community and addiction clinic pharmacists, with relevant training. In the UK, pharmacists monitor and assess patients and there are protocols in place whereby pharmacists can alter dose in conjunction with the treating GP. This is a resource saving initiative as it means patients do not need to return to the GP for every dose alteration, which is currently necessary in Ireland as it is illegal for pharmacists to dispense outside the prescribed dose.
			There should be aftercare programmes for all patients undergoing detoxification.
			We propose that secondary care dispensing facilities should be available outside the Dublin region to provide a service to patients whose drug use may be chaotic and who require stabilisation.
			The dissemination of information to GPs and community pharmacies on services in the local community that are available to provide support to patients, and which offer detox and rehabilitation would be a valuable development. GPs and pharmacists should be encouraged to refer patients to these services. New treatment facilities have opened on which GPs and pharmacists have little knowledge - an assessment of these services linked to dissemination of information about them would be a valuable development. We are unaware whether such non-statutory services are monitored or conform to an established standard.

Sub. ID	Source if individual	Organisation	Submission
52		Sex Workers Alliance Ireland	All clinical staff should receive training around: 1) attitudes to sex work, 2) how to discuss sex, 3) how to effectively engage sex workers; and 4) referral and service options. It is important that this training is undertaken by a harm reduction organisation and does not have an ideological underpinning.
			All clinics should display posters relating to safer sex work. The creation of posters should involve service users informing the message.
			All service users should be asked if they are or have been engaged in sex work at an early point in clinical assessment. If so they should have an instant safer sex intervention by an appropriately trained individual and should be offered referral to community and voluntary specialist sex work services.
			Reduce Community Clinic Residential requirement to 3 Months. Clinics have different requirements for how long an individual has to be in the area prior to them being able to access a local clinic. In some cases these regulations exist due to agreements made with local residents at the establishment of clinics (i.e. the Mews, Dublin 7). In all cases the residential requirement should be reduced to 3 months to assist with the management of waiting lists and encourage treatment in the community. Where this involves residents committees, agreements should be re-negotiated.
			Service users should be moved from clinics to community GPs / (or clinics in the case of Trinity Court) more readily. The issue of benzodiazepines should be reviewed in relation to this. Also case managers in the community and voluntary sector should be involved in supporting this move.
			Reduction of Waiting Lists. The KPI for methadone waiting lists is not being met. Within the Dublin Central area this is particularly relevant in relation to Trinity Court/NDTC. When working with chaotic users by the time the place for treatment becomes available then there may be no motivation to avail of the treatment option. Reduced waiting times for methadone are a priority for service development.
			Clear Pathways for Detoxification and Stabilisation. Standards should be developed for all methadone prescribers. This should include all doctors having a clear outline for the process to be undertaken for detox and stabilisation. In no case should requests for detoxification be refused without a clear pathway being outlined and appropriate supports being referred to. Standards should be agreed across services and GP co-ordinators should be tasked with ensuring that all GPs are aware of these requirements. Any complaints in this regard should be dealt with by the GP co-ordinator.
			Review of Methadone Reduction Policies. A number of services users who have had their methadone scripts reduced due to their illegal drug use find themselves in a difficult catch twenty-two situation, there should be a review of policies regarding weighing up the risk of overdose in this situation against the continued risks of use.
			Removal of Sanctions that Reduce Methadone Maintenance. There should be review of the service experiences of sanctions particularly in relation to reduction of methadone. Other non punitive practices should be introduced to assist with behavioural management. Each clinic should have an active inclusion policy which identifies how the service manages behavioural difficulties while maintaining appropriate levels of service provision.
			Utilisation of Positive Re-enforcement / Contingency Management. We would like to see clinics taking innovative approaches and creative approaches to rehabilitation such as contingency management.
			Opening hours should be extended to evenings. This would facilitate groups like sex workers to access services more easily. It would also facilitate the re-introduction of individuals to the community by providing better options for day time activity such as employment and courses. While there is guidance that individuals should be facilitated to receive early morning prescribing to facilitate attendance at university or college, this is not always happening. Clear guidance should be provided to all prescribing doctors on this and the appeals process should be established to manage non-compliance from medical practitioners.
			Prison based issues. Prisons need to engage with key workers / case managers around appropriate supports for of sex working individuals prior to release. A reliable system needs to be established in this regard. Release from prison raises numerous risk situations in relation to overdose, unprepared sex work and lack of accommodation and well developed system surrounding release would assist in reducing these risks.
54	Dr Patrick Troy		GPs who refer clients to rural drug treatment clinics need to take back these patients once stabilised. This is not happening in most cases. The ICGP have failed in the main to entice rural GPs to accept these patients back despite offering ease of training, lowering of training standards and requirements for Level 1 and 2 GPs.
			Allowing Level 2 GPs to provide treatment from other locations would substantially change the treatment spectrum and bring much needed drug treatment services to rural areas. Current situation of addicted persons having to travel from rural locations to Dublin for treatment is not sustainable.

Sub. ID	Source if individual	Organisation	Submission
55		South Western Regional Drugs Task Force	Desire of the service user should be paramount to their treatment plan. Detoxification should be rewarded and incorporated into a clear and manageable care plan, ensuring increased medical, psychological and family support. They key to maximising community and residential detox is to ensure that should the service user find they are lapsing or indeed fully relapse, that the service is still there for them and they are not deterred from detox, by receiving a timeframe before they can access the service again or go back on a waiting list.
			In the absence of HSE satellite clinics, GPs should be entitled to utilise the resources of community based projects in providing for the care of service users inside and outside general practices. Primary Care teams should also be able to link with trained GPs as specialists inside or outside of the location and care should be tailored to the needs of service users and not guidelines or bureaucracies.
			The MTP has worked well in Dublin, however service levels outside Dublin are poor. In reviewing the protocol it should be examined on a regional basis, and if required, protocol arrangements as per the needs of particular regions.

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56		Citywide	Access to services within one month of initial assessment priority in NDS, but waiting lists continue to exist, in Dublin Trinity Court reports waiting lists of 4 months plus, outside Dublin these are even greater and as a results people are travelling to avail of services in Dublin which in turns overloads these services. Access should be within one month irrespective of where users reside.
			Coherence and co-ordination of treatment at operational level. Case management would allow for prescribing rationale to be discussed; all clients should have a right to have a nominated person (a Service Users Advocate) to be involved in their care plans.
			Service capacity. No guidelines in current protocol that offer suggestions for what services should so once they reach capacity - clinics should be given similar limits to those of GPs so that appropriate treatment may be delivered to clients. We suggest guidelines for best practice in relation to numbers attending methadone clinics are included in the protocol so that the NDS can be completed, with new services opened where demand exceeds supply
			NEX. Provision of methadone services must include a widely available and easily accessible needle exchange equipment, advice and services. For many IV drug users, the MQI exchange is the only service available
			Coherence and co-ordination of treatment at operational level. Local protocols on agreed shared care of clients should be implemented in all areas. Multidisciplinary teams should be developed to operate case management which should include the prescribing GPs and the projects who work closely and daily with the client in supporting their treatment, detox and rehab.
			Not all clients need to be seen every week. In Britain community teams meet the client every 2 weeks to assess them on a formal basis and discuss progress/make recommendations on dosage - we believe similar arrangements should and can be contracted here
			Nurse Prescribers in Addiction. More nurses should be recruited and their services should be available in community settings across the country, particularly in services outside Dublin. A priority given the reluctance of many GPs to provide methadone treatment.
			Community detox. Protocols were developed between voluntary and statutory services in NICDTF area outlining how key workers/case managers with voluntary services could support prescribing doctors in the provision of community based detox for methadone and benzos. 18 month review was positive. Initiative should be extended to all task force areas.
			Sanctions. Reducing methadone as a sanction has to be addressed. For no other treatment would the removal of medication be tolerated as an acceptable intervention. Detrimental affects on the community, family and projects also.
			Reduction of methadone dosages by GPs. Many service providers report unexplained unwillingness on behalf of some GPs to engage in reducing methadone dosage for clients. This is often despite the fact that this is the client's stated wish. As a result some clients are reducing dosages themselves except when they have to go to pharmacies, at which points they take more than they have become use to leading to obvious complications - this requires immediate attention. Community drugs projects are more than willing and able to assist GPs in navigating through this process.
			Access to services after detox. Client fear that if they detox they will not be able to link back in immediately with local services and programmes - projects know of clients staying on very low doses in order to keep access to prescribing services. Clients should be allowed to re-engage with drug services if they relapse within 2 years as part of aftercare treatment.
			Treatment and rehab in prisons. The fact that not all prisons are in a position - or are willing - to provide methadone maintenance treatment is an issue that needs to be addressed within this protocol. We ask that clear guidelines on the benefits and 'how to' regarding the provision of opioid replacement therapies in prison be provided within the protocol
			Prison to community transition. To ensure that people upon release have full access to thorough care for treatment services, the IPS must make contact with relevant Community Prison Link Workers before any prisoner is released.
			Initiation of methadone treatment in prisons. Treatment services within prisons must be able to initiate methadone treatment for prisoners where a community treatment place is not available upon release. This is particularly important where waiting lists are in operation. There should be no delay or loss of treatment for a person simply because they leave prison. We have had reports of people being retained in prison after they were due for release because there was no community treatment place available. This practice is totally unacceptable and should not continue.
			The IPS Drug Policy & Strategy Monitoring Group, which was established to consider progress made in the implementation of the Irish Prison Service Drugs Policy, must be reconvened and its work completed within an agreed time frame.

Sub. ID	Source if individual	Organisation	Submission
57		Tallaght Local Drugs Task Force	Opportunity and supports to enable client detox should be made available to all regardless of local HSE policy.
			Detox for poly-drug users. Consider detox opportunities for methadone treatment patients who are poly drug users and/or using alcohol.
			There should be more beds for detox.
			Recommend the roll out of NAHB policy on detox - patient choice after one month of clean urines, with a view to developing a signed agreement to prepare for detox.
			Secure methadone treatment card beyond 28 days for clients entering detox so they are not on a waiting list if they relapse.
			Detox and urines. Develop protocols with the HSE to share where appropriate the signed release of urine results, for example with residentials, GPs and community/voluntary rehabilitation support organisations.
			Detox for under 18's. Detox and accessible, affordable residential treatment opportunities for under 18's.
			Security for detox units needs to be put in place to ensure safety and security for patients whilst detoxing without any availability or temptation of unprescribed drugs.
			Patient choice where possible should be facilitated and clients provided with a menu of treatments rather than just methadone.
			Treatment of clients in the community should be enabled and supported
			Treatment protocols to continue to build on the strength based approach
			Wrap around services and supports with private GPs for methadone treatment patients (integrated four tier model of care) and collaboration with NDRIC rehabilitation framework guidelines (supported integrated pathways and protocols, SLAs in particular)
			Provision of treatment guidebook for patients, with treatment and targets to evidence a transparent and fair system outlining how decisions are made etc.
58	Dr Moosajee Bhamjee		Ireland needs a proper Addiction Policy with Detox facilities and Rehab Units. There are very few heroin detox beds in Ireland i.e. max 20.
59		Jobstown Assisting Drugs Dependency Project Ltd	Concerned that the MTP is not addressing the needs of polydrug users. The protocol effectively treats heroin/ opiate misuse, but has it distracted service provision from the needs of misusers of other drugs/polydrugs users? The high levels of chaotic polydrug use among clients on the methadone protocol and the high incidence of drug-related deaths among polydrug users are a concern that methadone services need to consider.
60		Irish Association of Alcohol and Addiction Counsellors	Reduced waiting times for methadone should be a priority. The KPI for methadone waiting lists is not being met. When working with chaotic drug users, by the time the place for treatment becomes available the motivation to avail of treatment may be gone.
			Review of methadone reduction policies. A number of services users who have had their methadone scripts reduced due to their illegal drug use find themselves in a difficult catch twenty-two situation, there should be a review of policies regarding weighing up the risk of overdose in this situation against the continued risk of use.
			Regular reviews for all service users receiving methadone maintenance. All service users in the clinical and GP setting should have regular reviews of the medical regime and should be asked whether they are happy with the existing situation or whether they would like to detox, reduce medication or require stabilisation - this should be recorded on file. Well managed reviews could provide valuable motivation and care planning opportunities.
61		North Dublin City and County Regional Drugs Task Force	Need for additional services in the region. Currently there is access to detox and some rehabilitation however there are areas within the region with a lack of Level 1 and 2 GPs and pharmacies dispensing methadone.
			Greater consultation with service users would be useful in terms of individual care plans and a client's right to decide on treatment options. The involvement of families, as primary care givers, would be advantageous also.
			Education, information and support for both the service user and their families would support the current treatment options in the region.
			Suboxone and other alternatives to methadone could be offered to clients in addition to family support, counselling and information as a holistic treatment model.
			FAS CE Scheme places are not being utilised as an additional resource in the region, research into the poor uptake in this area could be explored. FAS waives the normal criteria for those who have or are currently experiencing substance use issues.
			Appeals process for clients should be considered in all areas relating to treatment - from refusal of choice.
			Difficulty faced by national voluntary organisations in relation to funding to run services. There is a need for a central funding mechanism on a client by client basis to ensure that clients accessing non-HSE treatment services can also avail of detox and treatment in a timely manner. Models such as the Rutland Centre, where medical cards are accepted appear to work well. If funding was provided centrally organisations could provide the same level of care as detox services like Cuan Dara.

Sub. ID	Source if individual	Organisation	Submission
62		The Cornmarket Project	There are no methadone services in Wexford; clients have to travel outside of county for these services. This disrupts the psychosocial and rehabilitative elements of the individual clients care plans and makes it very difficult for those clients to fully engage with our drug treatment and rehabilitation project. The lack of methadone services also has implications for the health and safety of our clients who want to move away from chaotic heroin use.
63		UISCE	Choice of Methadone brands. There are issues with methadone such as constipation, flatulence and sweating. The flatulence side-effect we understand to be a result of the syrup added to methadone to prevent injecting. We feel this is over-cautious and prevents the wider use of more concentrated forms of methadone (e.g. 10mg per 1ml). Concentrated methadone is also useful for people travelling. The brand of methadone is also an issue for some in OST. We have raised this issue before and were informed of the EU legislation governing the tendering process that has to be adhered to, which has resulted in just one brand of methadone being dispensed in HSE clinics. However, it is our understanding that the choice of brand is becoming increasingly restricted in community settings also, as community pharmacy seem reluctant to dispense more than one brand due to paperwork;
			Alternatives to methadone for opiate substitution treatment should be available, including Suboxone and Subutex. We acknowledge the barriers to buprenorphine are financial, diversion/injecting, supervised dosing and resistance to change.
			Access to treatment is a serious problem, particularly outside the Dublin region.
65		Medical Staff Committee, Addiction Services HSE Dublin North East	Access to methadone treatment outside Dublin is currently very poor. There is a clear need in many regions for local HSE-delivered services alongside GP involvement. There is a great paucity of HSE clinics and the general practice setting alone is inadequate for the management of highly complex cases that are typical in addiction medicine.
			Transient and homeless addicts present a particular challenge. In Dublin, Trinity Court is overloaded and long waiting lists apply for this group. The Safetynet services is a welcome initiative which has improved care for this group.
			Models of care. Our clinics are not simply 'methadone clinics; and we do deliver individualised addiction treatment. We recognise that a chronic, chaotic heroin injector requires a different approach from a younger addict with a short history of heroin use. We wish to offer treatment choices, including detox options as well as residential care to patients, particularly to less chronic addicts.
			Choice of treatment. Members of our group have had a positive experience with Suboxone. While acknowledging concerns relating to misuse of Buprenorphine, we believe it is wrong to have no alternative to Methadone to offer. Subutex, a cheaper alternative, has not been made available. Ireland differs in this regard from the rest of Europe.
66		HSE Social Inclusion	Polydrug use issues. The interplay between different drugs, including alcohol, and how services respond effectively to polydrug use is an ongoing issue and one which the HSE continually tries to address. The forthcoming national substance misuse strategy is an important milestone whereby Ireland will have a national policy that incorporates alcohol and illegal drug use. An ongoing challenge is that of balancing increasing demand and increasing numbers coming into treatment alongside budgetary and employment controls.
			Integrated client-centred care. Our priority is to place the client/patient at the centre of service planning and delivery, balanced with the critical factors of care, governance, quality and safety.
			Changing times. The landscape of drug use and supply has changed since the Methadone Protocol was developed and last reviewed. Considerable changes have taken place to the structure of health services and to other key government and allied structures during this period.
67		HSE Addiction Services Medical Staff	Treatments should be evidence-based and appropriate to the individual at that time.
			Buprenorphine is widely used internationally for the treatment of opioid addiction and should be made generally available in Ireland.
			Treatment to a drug user in a GP setting is an efficient arrangement which should be expanded. Given the obvious need to make treatment more accessible (and in some areas to provide any treatment) to heroin users, we recommend expansion of this scheme. To this end, the maximum number in treatment with each GP should be increased and Level 2 GPs should be allowed to practice from more than one location. Increasing the number of Level 2 GPs by allowing experienced doctors to provide Level 2 services, even on a provisional basis pending an audit should be considered.
			Support for GPs treating drug users in their practice. These patients may not have the same access to supports such as rehabilitation and counselling which have traditionally been clinic based. The proposed rehabilitation pilot programs to facilitate integrated rehabilitation and support networks in the community are welcome and we urge the review to support such measures.
68		Irish College of General Practitioners	Explore the role of Nurse Facilitators to assist with the running of the MTP. Many GP practices are training their practice nurse to assist with the management of patients on the MTP. Particularly when patients are stable and where there is an agreed protocol between the GP and practice nurse around when to refer, the skills of the practice nurse are a very useful asset in this area. In areas outside of Dublin where waiting lists in general are much longer, this model of care could be defined and a role for Nurse Facilitators developed.

2. To review the MTP with regard to Clinical Governance and audit

Sub. ID	Source if individual	Organisation	Submission
1	Dr Garrett McGovern		GP clinical autonomy. GPSSAs, as stated in their contract, are clinically autonomous. They have developed a significant level of expertise in treating drug users. They have set up a citywide CME facility and a number of GPs have postgraduate qualifications in addiction. It is important that GPSSAs are central to any proposals regarding clinical governance and audit
2		Addiction Services Dublin Mid-Leinster South Western Region	Membership of audit committee. Consideration should be given to the inclusion of a representative of the Quality and Clinical Care Directorate of the HSE on the Joint Audit committee to strengthen clinical governance.
			GPs. The clinical governance of both Level 1 and Level 2 GPs should be clearly outlined so there is a clear pathway for clinical governance through the ICGP and ultimately to the Medical Council.
			Residential detox. Where detoxification is taking place in a residential setting this should be supported by an appropriate clinical governance model.
5		SharingPoint	Clarity & transparency. Critical that standards and guidelines for operation of methadone treatment are clear and transparent to both potential users of the service and the GPs who operate the service. Service users need to understand what will be expected of them on the programme. Doctors/GPs should have clear guidelines and standards on how detox and stabilisation are to be managed.
7		CARP-Killinarden	Prescribing. Need a clinical governance for the prescribing of methadone that is common to all prescribers
			Protocols. Clinical protocols should be in place in all clinics and reviewed regularly
			Service user choice. Service users should be entitled to choose to do a detox or maintenance programme on methadone. It should not be a medical decision alone.
			Ethos and personal beliefs of doctors/institutions. We should have a methadone protocol that people are obliged to follow despite the 'personal' beliefs of the prescribing doctor/institution . Clinical/residential groups should be able to employ medical people who share their ethos.
13	Dr Hugh Gallagher		The audit needs to be broadened to take account of matters of rehabilitation and care planning.
17		OMD	Development of comprehensive guidelines for managing patients should be put in place in line with the recommendations of the WHO guidelines. The issue of ensuring adherence to guidelines and developing procedures, including for appeals, to manage non-adherence to key aspects of guidelines is critical to ensuring that there can be full confidence in the protocol.
18		Northern Area Voluntary Cluster and Dublin North Inner City Drugs Task Force (submissions received seperately, merged here due to crossover of themes)	Audit of referral pathways. All methadone prescribers should receive audits on care plan / medication reviews with all service users. Any practitioners who do not meet standards should be facilitated to do so. Variance tracking should be included to assist in identifying potential cases where there has not been appropriate supports offered.
			Appeal process. An independent appeals process should be established for all prescribing decisions affecting service users. It should be quickly activated and genuine in nature, taking into account the existence of collegial affiliations, the need for a service user first approach and the involvement of advocates. This would be utilised once informal mechanisms of responding to the situation have failed.
26		SAOL Project	Flexibility within the protocol. Whilst supportive of the need for a protocol, there should be a traceable, controlled flexibility within the system, which would protect doctors who have a legal duty to fulfil the conditions of the protocol but who also want to assist a client in out of the ordinary circumstances. For example, a maximum of seven day takeaways inhibits a client from going away on holiday for longer than a week.
27	Dr John Moloney		Audit should evolve in accordance with Medical Council Guidelines. As far as the addiction service is concerned there is a process in evolution for Clinical Governance and I believe that this should proceed with input from front-line medical staff. There is a process of audit in operation and I believe that this should be continued.
			Need for clinicians to drive change. I believe that there has to be a strong clinical voice from the front-line of the service which administrators can include in their decision-making and I would like to make two concrete suggestions in this respect -a representative of the quarterly meetings should participate in the MPIC; There is scope for greater participation by doctors on committees and meetings within the sectors.
			Audit of outcomes. There should be an audit of outcomes – at the very least mortality within 12 months of leaving the "Detox" centre and it should not be difficult to arrange a process which would permit this.
			Self audit procedures for doctors who have had three audits should be developed. The nature of audit has changed for Irish GPs since the passing of the recent Medical Practitioners Act and the subsequent changes in the Medical Council. Doctors are now required to audit by law. I would hope that the process of audit will continue to evolve in the light of these changes and that in particular the facility for self-audit of doctors who have three formal audits is developed further and in accordance with guidelines issued by the Medical Council. Governance should be on the same basis as for other work undertaken by doctors in the community.

Sub. ID	Source if individual	Organisation	Submission
28		Tabor Lodge	Governance review should address the ethics of a service user being issued with a one-year methadone contract to remain on methadone - this is strengthening the dependence to opiate based substances. Concern that in this period of time the service user has no empowerment to pursue options of detox within the context of full treatment plan, for addressing rehabilitation needs and restoration to fully functioning lifestyle. The danger is that when services are limited, the person will be maintained on a methadone programme and that rehabilitation needs are never properly addressed
			Strengthening the voice of service users. The review needs to strengthen the voice of the service users in future protocol. It is also important that the service users who achieve recovery play a lead role in assisting service users towards a goal of abstinence and drug free lifestyle.
			Detoxification from methadone is a more protracted and difficult process than detoxification from heroin itself. Alternatives to methadone should be actively researched and implemented. Special emphasis should be given to drug free interventions as part of a detoxification process.
			Future reviews should be bi-annual and include a review of all funding involved in delivering the protocol with detailed analysis of funding to GPs, pharmacists, pharmaceutical companies and include accountability for this funding.
29		HSE Addiction Services Dublin North Central and Dublin North	Role of Chief/Liaison Pharmacist should be reviewed within the protocol and standardised nationally.
			Role of GP Co-ordinator within the Protocol. The GP Co-ordinator needs to have a clinical governance role and a formalised line management relationship with Level 1 and Level 2 GPs in the community as a national standard.
			Clinical governance needs to be delivered in line with HSE governance framework. All clinical staff should report on clinical governance matters to the Clinical Director and there needs to be clarification of the roles and responsibilities of all senior clinicians so that a seamless service is assured for the service user - job descriptions for all clinical staff within the HSE will need review to this effect. Contracts provided by the HSE to GPs and pharmacists should incorporate lines of clinical governance and accountability within their HSE contracted time.
			Clinical governance between GP specialising in substance misuse and Consultant Psychiatrists has long standing unresolved complicated history and this has led to difficulties in mapping the Addiction Services on to existing HSE governance structure. Imperative that this issue gets resolved to ensure acceptable governance for all.
			Audit of practice needs to be mandatory for all clinicians in the service. There needs to be a clear chain of governance outlined in relation to the audit and the role of the ICGP as well as the clinical governance structures in the HSE.
			GP contracts. There needs to be a clear protocol developed by the HSE for terminating contracts for GPs who have been deemed unsuccessful through the ICGP Audit and by the ICGP of HSE Audit Committee. Qualified GPs should only be considered in the future for prescribing and providing treatment on the methadone treatment protocol.
			ICGP Audit Committee. There should be a review of the roles, responsibilities and membership of this committee.
			Nurse prescribing. The methadone treatment protocol needs to consider/promote nurse prescribing.
			Service user involvement in designing and reviewing treatment delivery needs to be strengthened.
30		Soilse - Service Users	Awareness of addiction, more training, very judgemental and no consistency.
31		SOILSE - Staff	HSE should oversee clinical governance. All methadone treatment services should be subject to clinical governance standards; promoted, driven, managed and audited by the HSE. All stakeholders must be clear on their legal and procedural responsibilities and adhere to same. All clinical governance policies should be available publicly.
			Multi-dimensional remit, must be transparent and include service users. Clinical governance means standards and procedures are set, outlined and met including protocols and procedures for methadone treatment, detoxification and rehabilitation, including risk management, progression, inter agency work, patient advocacy and complaints, a multi dimensional remit. These components need developed sector wide. To this end clinical governance must seek to build a culture promoting transparency, service user ownership of their treatment and continual quality improvement. Audit should be implicit to underpin this process. It should lead to the accreditation of services to meet expressed and expected standards. The underlying fact is this process of internal professionalisation and monitoring is time consuming and does cost. However benefits outweigh costs.
			Lack of clear policies, procedures and guidelines sector wide. Audit provides options for change, promoting best practice and a quality culture. However it must be recognised that sector wide we still have a lack of clear policies, procedures and guidelines as to who does what and on what terms. This must be changed to enhance service organisation, delivery and integration. This represents a major commitment to sectoral development and training.
			Formal arrangements. In terms of formal organisation arrangements, chairs, committees and terms of reference, these should be named and reviewed annually. Also they should be written into job specifications and be obliged particularly if staff in services are contracted in to do specific work.
			Feedback from service users. Regarding customers, a feedback loop should be standard to gauge their opinions on service quality and delivery. This should be fed back sectorally at quarterly intervals and be on the agenda as mandatory.

Sub. ID	Source if individual	Organisation	Submission
33	Dr Colm Quinn		Opiate addiction and the ICGP. I question the necessity, value and rationale of the ICGP being formally involved with Methadone guidelines, policies and assessments. Whilst over 90% of methadone in Ireland is prescribed by "GPs" as opposed to psychiatrists or any other speciality, it is not in many cases as "GPs"; In the clinics throughout the country (apart from Trinity Court) it is by doctors specialising in substance abuse, so called GPSSA, of whom, I think, there are about 40 (I, myself, see about 160 patients a week). The Quarterly Meeting of GPSSAs which is formally recognised by the HSE Addiction Service and which we are paid and mandated to attend and which also run CME should be resourced by the HSE as a nucleus of expertise and experience in substance abuse. Our practice is constantly evolving; at our meetings there is a noticeable consensus regarding modifications of practice resulting from increased familiarisation with the problem, longterm relationships with the patients and aging of the cohort.
34		McGarry House	Clarity around the process of detoxification, stabilisation and reduction both for clients and residential staff with regards to take outs, increases and reductions of doses etc.
35	Dr Paul Quigley	Addiction Service HSE Dublin North East	Disjunction between policy and practice. The MPIC is made almost entirely of HSE staff, but lacks credibility and visibility in the eyes of the HSE's own practitioners. More transparency is urgently needed.
			Duplication in the formulation of operational policy, and desultory implementation. Medical buy-in to clinical policy has not been achieved at operational level and there are anomalies in the system. The clinic network is citywide and there is no rational for separate consultant-centred governance and policy processes.
			Rigid separation between maintenance and abstinence services. Need for more dialogue around the proper use of residential facilities and the best way to share available clinical resources among stakeholders.
			Barriers to co-operation between Addiction Services and Community Mental Health teams. Divergence between general and specialist psychiatrists continue to retard service development.
			Failure, over many years, to consult with experienced methadone prescribers about appropriate governance structures.
40		Irish Medical Organisation	GPs working with drug users are developing (through the GPSSA education committee) tools to facilitate peer review, competence assurance and audit.
41		FSN	Audit of referral pathways. All methadone prescribers should receive audits on care plans/medication reviews with all service users
			Appeals process. Needs to be speedier and more transparent. Fears that drug users may suffer the consequences of a family member making a complaint against staff, in terms of quality of treatment/sanctions
			Advocacy. When appropriate, family members should be allowed to act as advocated for their loved ones
43		Clondalkin Local Drugs Task Force	The prescribing of other sedative substances on top of methadone should be re-evaluated in the context of safety and polydrug use.
45		GPSSA Education Committee	Review of the ICGP/HSE Audit Committee needed.
			MPIC. Review of the role of the Methadone Implementation Committee
46		Drug Treatment Centre Board	Each service provider should have a Governance Statement that is signed off at national level.
			Audit should be expanded to include retention in treatment as a key element. Ultimate progression should be measured to identify if the patient/client is reaching the agreed targets/goals.
			Recommend the implementation nationally of an electronic patient system to support and further enhance current audit and governance requirements.
47		Ballymun Local Drugs Task Force	Management structures to support GP's in clinics need to be developed and in place. Disparities and inconsistencies can arise because the GP's are autonomous.
			Varying practices within and across drug services in terms of clinical standards of care. The revised methadone protocol is limited and is only very specific to prescribing services. Quality standards for drug services would greatly enhance good practice and current issues around quality of services and ensure all agencies in the addiction field are knowledgeable in quality standard practices.
			Development of benzodiazepine protocol to provide a more rigorous structured practice to the prescribing and review of their use (over and above the guidelines which currently exist). Current use of benzos among those accessing methadone needs further examination.
49	Dr Desmond Crowley		Role of consultant psychiatrists. The major difficulty in our services perceived by many is the relationship between the GPs and the consultant psychiatrist. The frustration for me personally is that often the psychiatrists have a limited view of the service. They deal with a very small percentage of our patients >10% and they then base their views of treatment on this group. They do not actively partake in chairing clinical team meetings and have moved further and further away from the front line. I believe also that in general the consultants in our service have a single approach to our services, all are Trinity Court trained. What we need is an injection of new blood with some different approaches and some international experience. Adherence to old practices is stifling the development of the service.
			Urgent need for resolve. Whatever the outcome of the governance issues, it should be resolved hastily - it is a long standing complex issues that has lead to a lot of distress and does not help in any way in the coordinated development of services.

Sub. ID	Source if individual	Organisation	Submission
50		Consultants in Substance Misuse	Structures and context. The consultant group recognise the importance of an appropriate clinical governance framework and the need for mandatory audit. Level 1 and 2 GPs in the community need to be involved in clinical governance in the first instance via the GP Coordinator then to the ICGP and ultimately the Medical Council. There needs to be regular meetings at Primary Care Network level to review caseload, supervision and CPD. Access to the opinion of a Consultant Psychiatrist in Substance Misuse would strengthen this governance structure. Alternatively the GPs could be linked into HSE Clinical Governance structures as they develop.
			Job descriptions' review of all involved. At departmental level consideration should be given to a review of the job descriptions of all the principals involved in the protocol.
			Criteria and organisation. The role, membership and responsibility of the joint HSE/ICGP Audit committee needs to be reviewed. Audit criteria should be expanded to include care planning and care planning review. Support for GPs who have failed an audit needs to be in place and how this impacts on the contract from the HSE will need to be carefully considered. An ongoing programme of CPD needs to be developed. Treatment outcome measures should be routinely collected and monitored by the ICGP and HSE.
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Problems of being unable to contact a GP who may provides treatment for one or two sessions only per week. This issue arises when a patient has been unable to attend his GP and arrives at the pharmacy with no prescription.
			The models of detox followed and services offering them should conform to authenticated, evidence based practice and that audit of successful and other outcomes of detox should be implemented.
			HSE role in audit of implementation of MTP in community pharmacy. Consideration should be given to developing a formalised audit to ensure best practices are met. Query whether the HSE, as contractor for services of the community pharmacy, should play a role in this. Clinical governance and audit in community pharmacy are currently the remit of the Pharmaceutical Society of Ireland.
56		Citywide	Dosage and polydrug use. New directive needed on best practice when the client is using more than just heroin and when prescribing methadone to those who are positively engaged with psychosocial programmes - particularly where large doses of methadone may limit the positive impact of therapy.
			Currently there is no clear appeals process for clients in relation to decisions made by prescribing GPs. This is unfair and contrary to actions 3.1/3.2/3.3 of the National Strategy for Service User Involvement in the Irish Health Service 2008-2013.
			Cross-prescribing of benzos. Benzos are reportedly consistently the second and third most common addiction substance used. Report of the Benzodiazepine Committee issued guidelines for prescribing, which in the experience of most projects spoken to by Citywide are not being implemented. Cross-prescribing continues to occur and co-ordination mechanisms for such prescribing need to be implemented and at least commented upon by the new protocol.
57		Tallaght Local Drugs Task Force	Develop MTP Guide outlining co-ordination, management, working methods, patient voice, impacts, outcomes, integration, evaluation.
			Recommendation of methadone GP time and clinics (a) to increase clinic places and/or (b) GP have more responsibility for patient general health rather than just methadone.
59		Jobstown Assisting Drugs Dependency Project Ltd	Are the guidelines for the MTP being adhered to? Particularly in relation to 1) review of methadone clients after 5 years, and 2) response to chaotic polydrug use.
			Is there sufficient communication between GPs and methadone prescribing doctors, particularly in relation to prescribing benzodiazepines?
61		North Dublin City and County Regional Drugs Task Force	Need for uniformity around treatment of clients with benzodiazepine use wishing to avail of the methadone scheme and/or detox, particularly around GPs. The clinical governance is for detox from methadone, however many clients on waiting lists nationally require a dual treatment model to detox from benzodiazepines also.
			No mention of voluntary organisations providing detox with HSE clinical governance on the HSE website.
			Uniformity and standardisation of treatment should be explored further. Guidelines are available for reference and although GPs use these, methods towards greater standardisation should be explored.
63		UISCE	Sanctions issue still of concern. One area of unfairness surrounds "takeaways" - for a patient to get one "takeaway" they need to provide a month of "clean" urines, however the same patient will lose a "takeaway" for every week the urine test is positive for illicit opiates i.e. it takes a month to get a "takeaway" but just a week to lose one. The use of punitive sanctions which involve significant dose reductions, and even curtailment of treatment altogether, should be discontinued. People's treatment should not be discontinued as a punishment.

Sub. ID	Source if individual	Organisation	Submission
65		Medical Staff Committee, Addiction Services HSE Dublin North East	Lack of transparency in the operation of the MPIC and lack of initiative in a number of important areas. Over the past 6 years a number of submissions have pointed out the issue of safety with handwritten methadone scripts, as well as the extraordinary waste of professional resources in handwriting them.
			We are in the process of establishing appropriate clinical governance structures for our work in the clinics, and a subcommittee has been established to progress the matter.
			A CME structure has been in place for several years. The monthly and quarterly meetings are well attended. In addiction, a peer review process has commenced, based on case analysis and discussion. Clinical audit processes will continue to be developed.
			The key role of pharmacists in provision of methadone treatment is recognised. To this end a joint sub-committee of DNE clinic doctors and pharmacists has been established. Ongoing dialogue is important to allow for discussion and resolution of difficult problems.
66		HSE Social Inclusion	HSE Quality and Clinical Care Directorate. We see the establishment of the HSE QCCD, whose role is to further strengthen clinical leadership and improve clinical performance as well as supporting the working relationship between clinicians and managers across organisations as an important step. A formal QCCD should impact positively over time on the systemic issues with regard to clinical governance that exist in our health services including the addiction services. We have supported and facilitated the Clinical Directors in Addiction Services linking in with the QCCD. Clinical leadership that guides, supports and provides standards and cohesion in the delivery of services is crucial and we hope that a revised methadone protocol will take cognisance of these structures.
			GP auditing. The system of auditing of GPs within the addiction services may be somewhat unique within the clinical setting and the view of the methadone review process on this process will be useful.
67		HSE Addiction Services Medical Staff	GPs working with drug users are developing (through the GPSSA education committee) tools to facilitate peer review, competence assurance and audit.
			ICGP Audit process needs review. Concern that GPs are being asked to practice based on the ICGP Audit Committee's interpretation of the guidelines, rather than what they perceive clinically as the best interest of their individual patient.
			ICGP Guidelines need to be evidence based, subject to regular and transparent peer-review and should be regarded as guidance for doctors and should allow individualised, patient-centred care. Concerns arise regarding ICGP guidelines on methadone dosing, take home medication and supervision.
68		Irish College of General Practitioners	Review of the Audit and Audit Outcomes. The ICGP/HSE Joint Audit Review Group (ARG) oversee the audit of community GPs providing methadone services in their GP practices. The ARG, which comprises representatives from the HSE and the ICGP, meets regularly to review external audits performed by the Clinical Audit Facilitator. This process has recently been reviewed and there will be recommendations made to encourage engagement and the acceptability of the audit. However, there are a number of issue which will require a formal review such as the terms of reference for the ARG and the role of the HSE as the contract holder.
			Care Planning and Audit across all treatment services. It is noted that there is no audit within the HSE treatment centres and satellite clinics which mirrors the ICGP/HSE Audit. In some instances this has created inconsistencies in the standard of care patients are receiving. A model of care planning needs to be standardised across services to ensure all patients receive the best possible standard of care and to ensure that all the treatment needs of the patient are being met regardless of the location where the service is.

3. To review the MTP with regard to effectiveness of referral pathways

Sub. ID	Source if individual	Organisation	Submission
Sub. ID	Source if individual	Organisation	Submission
2		Addiction Services Dublin Mid-Leinster South Western Region	Clear referral pathways are required for all agencies in the field of Addiction Services – the importance of the GP Co-ordinator in making transfers from Addiction Services to Community GP's needs to be maintained and strengthened if possible.
5		SharingPoint	Regular reviews for service users. All service users in the clinical and GP setting should have a regular review of their medical regime and should be asked whether they are happy with the existing situation of if they want to consider detox, reducing their medication or whether they require stabilisation. Service users should be given adequate information and support in making such decisions. Reviews provide valuable motivation and care planning opportunities. Records of review should be kept.
7		CARP Killinarden	Transfer of patients. We need a transparent protocol around transferring people with private GPs back to central clinics when they destabilise
9	John Craven	Dun Laoghaire Rathdown Local Drugs Task Force	Continuity of care should be a priority so as to provide a seamless service for clients. This is particularly relevant to those clients who are receiving methadone in prisons and are then released into the community at a weekend without prior treatment arrangements being made in relation to their care.
			Co-ordination between treatment and psychiatric services. Imperative that structures are put in place to allow for essential co-ordination between these services in order to ensure that clients with co-morbidity and needing psychiatric treatment are not disadvantaged by being on a methadone treatment programme.
10		Clondalkin Addiction Support Programme (CASP)	Linkages between community GPs and rehabilitation-type programmes underdeveloped and where developed, not always standardised. GPs should consider the broader services that could be of benefit to the individual.
			Continuity following transfer from prison to community. Transfer of clients to services in the community, particularly in relation to early release, can pose challenges in that the attending paperwork and necessary arrangements for prescribing & dispensing may not always be available prior to client being dis-charged. It should be noted however that this has improved greatly and whilst it may occur occasionally it is vastly improved over the last number of years.
17		OMD	Development of a comprehensive treatment and rehabilitation service is the key objective, providing treatment options appropriate to the needs of the individuals concerned. The recommendations from the Report of the Working Group on Drugs Rehabilitation and the National Rehabilitation Framework should facilitate such review and the identification of optimum referral pathways. These would involve exit from methadone treatment where appropriate.
18		Northern Area Voluntary Cluster and Dublin North Inner City Drugs Task Force (submissions received separately, merged here due to crossover of themes)	Inter-agency working from the perspective of prescribing clinics should be encouraged through KPIs, training, key working/case management policies, regular inclusion on agendas on meetings, engagement in interagency working forums/initiatives and provision of information to staff. Clinical engagement with voluntary and community drug rehabilitation and treatment services differs significantly from clinic to clinic. In some cases doctors show reluctance to have professional communication with external services.
			New communities & travellers. A specific strategy should be developed and resourced to address issues of lack of access to travellers and new communities. This would need to include proactive outreach as well as promoting the existence of confidentiality policies within the system. Services report that frequently people's concerns lie in the fact that their information will be passed on to other government departments.
19		Rialto Rights in Action	Annual review. There is no systematic review in process. There is a plan in relevant drug policies for a shared care plan system which would assign a key worker, build integration across agencies and have referral pathways but this is not in operation. An annual review is a necessary requirement in the realisation of the right to participate in the decisions that relate to the fulfilment of the highest attainable standard of health for people who are on methadone. This should be compulsory and meaningful in all treatment plans.
20		Traveller Specific Drugs Initiative, Pavee Point Travellers Centre	Inter-agency working will facilitate a more thorough holistic approach to the treatment of Travellers where the social and psychological issues can also be addressed.

Sub. ID	Source if individual	Organisation	Submission
24	Julian Pugh, Co-ordinator Drug Treatment Services (Prisons)		Transfer of care arrangements between Irish Prison Service and community methadone clinics for released prisoners who receive methadone has been monitored by a risk management audit system for nearly five years. This system is subject to oversight by a prison drug treatment co-ordinating committee and all incidents are followed up to ensure the integrity of care pathways is maintained. It has successfully reduced the number of incidents when released prisoners may arrive unannounced at clinics. The complexity of ensuring the proper release of prisoners and the continuity of clinical and rehabilitative care is compromised by the release decision making process in which release decisions are often made on the day of release. Similarly there are problems regarding committal of remand prisoners in that prison surgeries do not receive timely transfer of clinical or rehabilitation histories.
			Risk issues need to be addressed in relation to short terms prisoners who commence a methadone detoxification programme on admission to prison and are released without continuity of care being in place. Releasing prisoners without continuity of clinical care or continuation of methadone is very risky. This is particularly so regarding Dochas releases.
27	Dr John Moloney		There are very few safe and effective referral pathways to Residential Centres for Withdrawal of Opioid Substitution Treatment (WOST). There is a need for development of safer general admission criteria to residential WOST. There should be agreed criteria for suitability for admission to residential centres for withdrawal of methadone. These should be based on long-term markers of Bio/Psycho/Social stability. The autonomy of the patient should be evidently respected by third parties who should not pressurise the patient to enter programmes and the patient's right not to enter such programmes needs to be formalised. The patient should have free and informed consent which includes likely long-term outcomes and possible adverse consequences.
			Development of structures to formalise joint care with social services. This happens on an ad-hoc basis but could be formalised and developed. The limited efficacy of in-patient "detoxification" (Residential WOST) in achieving long-term abstinence needs to inform the approach of third parties who strongly advocate this course but who are not always in a position to observe the outcomes for patients and their families.
			Clinical liaison and transfer of clinical responsibility to residential WOST. Clinical transfer of responsibility for medical care of the patient should be clearly recorded when the patient is transferred to the centre and when the patient returns to the community. The community doctor should receive a discharge summary and details of follow-up. There should be a "Rapid Return Protocol" set up in advance to return high risk patients to methadone treatment, if required
			Audit of outcomes of residential WOST. There should be an audit of outcomes – at the very least mortality within 12 months of leaving the "Detox" (Residential WOST) centre and it should not be difficult to arrange a process which would permit this.
			Agreed protocols and a code of practice for transfer to residential WOST. There should be agreed protocols and a code of practice for transfer of care to such centres. Referring doctors should have a voice in drawing up these protocols. We need a collaborative process which includes the HSE, referring doctors and stakeholders in residential WOST centres to draw this up.
			Community based methadone clinics for non-residential WOST. Community based clinics should be supported as an alternative or complimentary locus for methadone withdrawal and social rehabilitation (non-residential WOST). In my experience the majority of patients whom I have referred for Detox and rehab have been from small community based local clinics (formerly known as satellite clinics). These have significant advantages in terms of rehabilitation and family involvement and collaboration with community drug teams. They also provide accessible follow-up for the patient who is attempting to withdraw from substitute treatment - and thus reduced risk of excess mortality.
28		Tabor Lodge	Referral pathways have note opened up for service users beyond the strict medical model of intervention. Four tiered treatment models presently exist that introduce a range of treatment approaches. These treatment approaches need to be developed and properly resourced and opiate users should be referred as outlined in the government rehabilitation report.

Sub. ID	Source if individual	Organisation	Submission
29		HSE Addiction Services Dublin North Central and Dublin North	Relationship between GP and Pharmacist is critical for review of the service user's treatment and care plan.
			Clear national criteria for suitability for treatment with Level 1 and 2 GP need to be developed and timely transfer for Level 1 and 2 GPs in the community when a service user fits the criteria for referral.
			Clear national standards of treatment need to be developed.
			Timely and easy transfer to the local drug treatment clinic when found to be unsuitable for continued treatment in primary care.
			Consideration of areas devoid of resources such as community pharmacists, local drug treatment clinics or Level 1 or 2 GPs. An absence of any of these resources will affect referral pathways.
			Protocol needs to facilitate specific pathways for more transfers from Level 2 to Level 1 GPs
			Need for ongoing care plan review and referral to other services i.e. CDTs, rehab services in the community, training and employment schemes, counsellors, psychiatric services, CWOs, etc.
			GP knowledge of support services. GPs need to have knowledge of support services locally that would be helpful for the service user. They need to know what is required to support a service user to detox, and have knowledge of detox services in the community and in residential treatment and rehab units.
			Progression. Being in primary care on methadone maintenance should not be a cul-de-sac but another means to progress.
			Monitoring of referrals. The ICGP Audit could monitor the level of referrals to other supportive services.
31		SOILSE - Staff	There must be a standard referral framework, detailing to service users the nature of the service they are receiving, including induction and naming who will facilitate this (e.g. key worker / case manager). All service users should have a Care Plan whereby the effectiveness of their progression goals is audited.
			Structures to facilitate integrated working. Strategically there needs to be a paradigm shift to a recovery / progressionary culture where the expertise underpinning referral pathways, namely training and organisational development are developed to enable this process. This includes the principles, process and policies of interagency work, teamwork, networking, communication, care planning and case management. There must be local integration structures to facilitate all services working together in an integrated way, like Primary Care Networks.
			Variance in access and referral. Access policies to different referral points often vary significantly. Many services, particularly the medical model, believe it is their prerogative to prescribe, not to work in a progressionary or integrated way. All available resource options including social, educational and rehabilitative programmes should d be engaged.
			Service promotion needed and development should reflect need. Services are badly advertised, often inaccessible and little information exists as to criteria's for engagement. Also a lack of services exists often in areas of high need – evidence of the uneven development of services – which adversely affects accessing referral pathways. Dublin's north inner city is an example. Budgets and resources should be rebalanced to meet need, not dispensed on an equal geographic basis.
34		McGarry House	Clarity around the referral process, waiting lists, prioritising clients deemed more vulnerable or with health issues and those moving county - it has been found that prescribing differs from county to county, and between practitioners.
37	Dr Declan O'Brien & Dr Don Coffey		Medical provision of methadone and counselling bottleneck. Referral pathways are recognized by clients, community drug works and health professionals, the bottleneck would seem to be the medical provision of methadone and counselling.
41		FSN	Referrals to family support. Those delivering MMT should be familiar with the concept of family support and the value of it and be supported and encouraged to make referrals to the FSN/local family support groups for the family members of those they are treating.
			New communities and travellers. Need for specific strategy to ensure access to treatment by new communities and travellers - these groups are particularly hard to reach. Work is needed to build up trust and encourage access.
42		NDRIC	All service users should have a care plan in place and a shared care plan where necessary. There is a specific protocol outlined in the National Drugs Rehabilitation Framework in relation to care planning. Care planning is a key aspect of this Framework and the NDRIC feel it should also be clearly identified as a component of the methadone treatment protocol. The Framework was developed to facilitate integrated care pathways for drug users and to inform inter-agency working. We feel that a service user's Clinics/GP's should both input to this care plan and be part of a team that provides shared care to that individual. We need to recognise the aspirations of many service users to achieve a drug free lifestyle. To this end the NDRIC Framework Document seeks to enable this process.

Sub. ID	Source if individual	Organisation	Submission
43		Ballyfermot Advance	Clear and transparent referral pathways must be developed between the community and voluntary sector and addiction services, regardless of catchment area.
			Clients feel that rehabilitation should include residential options and that clear pathways need to be available to them. More intervention is needed, not just medication.
			More addiction workers within clinic/GP settings needed to establish referral pathways for clients, which would be individually designed to open up additional supports for the person beyond medication.
			Appropriate sharing of information and inter-agency co-operation between referral agencies must be fostered, between statutory and community/voluntary agencies.
			A central point for all referrals must be created with clear information of positioning, time frame, etc, available on a weekly basis for the client or their referring agency.
46		Drug Treatment Centre Board	A need to further enhance interagency working and to provide evidence to demonstrate and enhance the effectiveness of the care pathways and outcomes in respect of treatment and rehabilitation. We recommend the implementation of a national patient system and national agreed pathways to support this process
			The planned progression of referral pathways is often dependent on the availability of services within a geographical area. We suggest each geographical area should have increased community support for care pathways to support a wider range of options in respect of treatment and rehabilitation. We also recommend increased emphasis on psycho social treatment to support relapse prevention.
47		Ballymun Local Drugs Task Force	Intra-agency services (within the HSE) are not always fully maximised in the interests of the clients. Increased communication and more seamless internal referral procedures would benefit clients that may present with other additional issues - such as dual diagnosis.
			Referral across sectors. Community and voluntary agencies which are shown to adhere and comply with quality standards frameworks to be accepted as outside referral agencies and involved in joint/shared case management of clients.
			System needs to be more facilitative for those who wish to progress from methadone. This could be achieved through: liaison with other services; service-user participation; advocacy; goal setting; care planning; co-ordinating and delivering care; communication between services; inter-agency information sharing protocol; and enhancing the progression outcomes through the provision of ancillary services.
49	Dr Desmond Crowley		Inter-agency awareness. It is important that Statutory and non-Statutory are aware of services provided by each.
50		Consultants in Substance Misuse	Transfer criteria. GP coordinator needs to ensure that appropriate criteria are met to facilitate transfer of patients to primary care from clinics. Stable patients need to be able to transfer from a level 2 GP to a level 1 GP to free up space at level 2 in the community.
			Referral pathways need to in place from the Primary Care setting to appropriate rehabilitation options in the community. GP liaison nurses may be of benefit in this area. A clear referral pathway back to substance misuse services needs to be in place as it already exists in the greater Dublin area for those patients who destabilise.
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Delays in commencement and transfer of treatment occur because there is a delay in processing paperwork (written confirmation of treatment follows before commencement) - we recommend that this should be reviewed.
			There may be resource implications regarding the use of a standardised form between agencies and services to progress service users through the continuum of care.
			Community pharmacy requests that service users sign service agreements on first occasion when they attend the pharmacy, as recommended by PSI Guidelines. This may be controversial as no other groups of service users is requested to agree to certain behavioural requirements.
52		Sex Workers Alliance Ireland	Clinical KPIs extended to Include Referral Pathways and Interagency Working with Voluntary and Community Drug Services. Chrysalis, which is working from case management perspective as described in the Progression Routes / Homeless Agency case management protocols, has had significant success in working with local clinics and with sex workers. It is our recommendation that the NDRIC should be strongly encouraged to ensure that nationally developed systems make provision for low threshold voluntary / community services to work as case managers.
			All clinics should have KPIs that stipulate the need to work with all relevant community and voluntary organisations. This should be reviewed. Too frequently key workers/case managers working with drug users in clinical setting, find it difficult to communicate with doctors and other staff in the clinical setting. A policy is needed which necessitates letters and phone calls to be returned.
			Sex work focused organisations should be funded to case manage sex working/drug using clients.
55		South Western Regional Drugs Task Force	Referral pathways need to be inclusive of pathways into treatment and different phases of treatment, as well as different locations of treatment (hospital, prison etc.). Exploring the referral pathways is only the beginning of the treatment journey and how prescribers interact with external supports and agencies should also be examined.
			Improving referral pathways effectiveness. The NDRIC Framework and also the Berkshire 4 Way Agreement should be explored in relation to improving effectiveness. This shared care approach offers the service user an improved continuum of support and means the service provider is not working in isolation (research indicates that rural GPs may feel too isolated to work with substance users).

Sub. ID	Source if individual	Organisation	Submission
57		Tallaght Local Drugs Task Force	Pathway between community, stabilisation units, detox beds and residential needs to be improved, including timelines for clients progression and enhanced seamless pathways.
			Relations and SLAs between HSE and non-HSE agencies need to be enhanced with a view to continued care and cross boundary transfer/referral of clients.
			Development of protocols to enhance the pathways of care e.g. GP signs off patients to residential care or community clinic and GP is contacted when they return from residential or arrive/return to clinic.
			Comprehensive understanding of 'stabilisation' by clinicians, community and patients.
			Explore case meeting processes and procedures: decisions for and with the patient should facilitate a holistic overview and where appropriate include the patients support network of family, community, counsellor etc.
			Consider the MTP in collaboration with a variety of supports and interventions with a view to polydrug use treatment.
			Referral pathways should be formalised as protocols in the best interest of client support and progression.
			SLAs between agencies to facilitate cohesion for clients from first point of contact with continued supported referral. Patients as the core stakeholder to be informed about what's happening and/or what is on offer.
60		Irish Association of Alcohol and Addiction Counsellors	Requests for detox should not be refused by doctors. There should be clear pathways for detoxification and stabilisation. This should include doctors having a clear outline for the process to be undertaken. Requests for detox should not be refused without a clear pathway outlined and appropriate supports being referred to. Standards should be agreed across services and GP Co-ordinators should be tasked with ensuring all GPs are aware of these requirements. Any complaints in this regard should be dealt with by the GP Co-ordinator
61		North Dublin City and County Regional Drugs Task Force	Different case management models used by different agencies and often it is unknown of the client's progression once they have left a particular service. Referral pathways appear to be clinically dominated. The principal of the NDRIC is good, however additional resources are required if it is to be effective.
65		Medical Staff Committee, Addiction Services HSE Dublin North East	Importance of psychiatry. Psychiatrists in substance misuse and general psychiatrists in the community mental health setting are valuable resources for our work. We are in the process of discussing and clarifying our working relationship with both of these groups.
			General practice. We intend to promote greater dialogue between clinic doctors and prescribing GPs. Our involvement in primary care teams needs to be progressed.
			Rehabilitation. Residential facilities are an expensive resource, and there is considerable problems with access. There needs to be much more dialogue around their proper and effective use.
66		HSE Social Inclusion	Open and clear referral pathways. The work that the HSE has been doing with regard to rehabilitation has brought into sharp focus the need for effective open and clear referral pathways along with case management and working across and within agencies.
68		Irish College of General Practitioners	Improved inter-agency communication. At present the communication between treatment agencies and with community GPs is less than ideal. Patients are often transferred via a telephone call with no follow up documentation/transfer summary forwarded to the family/Level 1 GP. Communication from the prison service when clients are being discharged is particularly random. Due to the high risk of overdose on discharge from prison, communication from the prison authorities to the treatment agencies or GP should be made a priority. Similarly, communication between relevant agencies when patients are entering or completing a detox is important at this is also a high risk time for overdose.
			Facilitate the transfer of suitable patients to Level 1 doctors. There continues to be under-utilisation of existing Level 1 GPs. Many of the GPs who responded to the ICGP survey, indicated that they would be willing to take more patients but they had never been asked to do so. This suggests there could be a more formal process by which satellite clinics, treatment centres and level 2 doctors should identify suitable patients for transfer to the community. At present there is no onus or incentives for patients to be transferred back to their family GPs.
			The family GP should be integral to all MTP treatment episodes. A system of referral needs to be established where the patient's family GP is integral to the referral process. This referral pattern is recommended by the Medical Council. Many GPs are now willing to provide ongoing methadone maintenance to patients registered in their practice. Engaging with the family GP through regular communication and a shared care card provides support for GPs who are willing to take back their patients. It is accepted that there may be times when this cannot be implemented but these situations should be the exception rather than the rule.

4. To review the MTP with regard to the enrolment of GP's, the training of GP's, the criteria for Level 1 and Level 2 GP's, and the GP co-ordinator role

Sub. ID	Source if individual	Organisation	Submission
1	Dr Garrett McGovern		Lifting GP patient caps and single location working. GPs have played a pivotal role in treating drug users since the implementation of the MTP in 1998. 95% of patients on MMT are treated by a GP. As heroin use us spreading rapidly in many parts of the country it is imperative that the needs of drug users beyond Dublin are met. This is not currently the case. There are 70 level 2 GPs in the country. They are capped in the numbers they can treat on the MTP at 35. They are also limited in that they can only work from one general practice. If the cap on numbers was lifted and GPs were able to work at a second location this would significantly ease waiting lists in areas of the country with little of no treatment. It is also imperative that community GPs, not currently involved with the MTP, are encouraged to treat drug users.
2		Addiction Services Dublin Mid-Leinster South Western Region	GP Training. Information on who has completed Level 1 and Level 2 training should be freely available to GP Co-ordinators. Generally both Level 1 and Level 2 training is of a high standard but the issue of CPD should be considered for participating GPs to ensure continuous updating of skills.
			The GP Co-ordinator role is critical and it is important that this role is actively managed and supported by the HSE as their employer.
			The role of the National Co-ordinator needs also to be examined and given the critical need for recruitment of GPs outside the greater Dublin area perhaps a GP Co-ordinator for each HSE regions outside Dublin would be more appropriate and enable more GPs to be recruited.
5		Sharing Point	GP Education. GP Co-ordinators should ensure that all GPs are given up to date and relevant information on their local drugs services and community supports so they can appropriately support the service users with whom they are working
7		CARP Killinarden	Level 2 GP's Caps. Level 2 GPs should not be limited to one stand alone clinics of 35 patients
11		Waterford Substance Misuse Service	GP model of service provision to opiate users not working in Waterford area. It is proving extremely difficult to recruit suitably trained GPs to work in the substance misuse area. With the documented increase in opiate problems in the Waterford area other options need to be explored to provide a service to this cohort of clients.
13	Dr Hugh Gallagher		Brief Intervention training should be provided and deemed a pre-requisite to participation in the MTP as a means to provide a basic understanding of addiction and also as a means to intervene early and effectively in new drug or alcohol use while on methadone.
			Training on-line is insufficient for participation in the MTP. Structured live training sessions should also form part of the training with a particular emphasis on issues of interagency working and rehabilitation.
			Addiction education should be provided on the neurobiology of addiction and regularly updated.
			A Handbook on the principles and practice of addiction treatment should be provided for education and reference purposes. The ICGP guidelines are wholly inadequate.
14	Dr Cathal O'Suilliobhain		Better use of existing Level 2 GPs. There are 70 Level 2 GPs working at present. Almost all of these have come from the clinic system and as a result are located in the greater Dublin area. Efforts to properly train Level 2 GPs outside the clinic system have only produced a handful of recruits. There have been suggestions recently of "Dumbing down" the level 2 training to produce increased numbers. There is no need to do this if the properly trained and very experienced cadre of existing level 2 GPs is used to its full potential.
15		Southern Region Drugs Task Force	GP Training. Level 1 GP training should be a requirement and recognised in the final year of GP training; this training should be required before license is issued.
16		Bray Local Drugs Task Force	More Level 2 GPs needed. The number of level 2 GPs is very low, in Bray there are two. This needs to increase to ensure maximum service delivery options for individuals seeking treatment.
17		OMD	Maximising local treatment for clients is a key objective of the existing protocol. While there is clear evidence of significant progress in this regard over the years, significant blockages still exist. We feel that the number of clients that Level 1 and 2 GPs can work with should be increased given the significant experience of many of the GPs involved. The roll out of Primary Care Teams across the county should also facilitate this approach.
18		Northern Area Voluntary Cluster and Dublin North Inner City Drugs Task Force (submissions received separately, merged here due to crossover of themes)	Case management and key working development to support Level 1 and Level 2 GPs. Where required, case management and key working systems should be recognised and developed as GP supports. The review of the community detox protocols provide evidence of positive practical supports that can be provided to GPs through co-ordinated key worker/ case manager supports to GPs; whom found that these supports were extremely useful in ensuring appropriate supports for service users.
			All level 1 and 2 GPs should receive information on local drugs services to support their work.
			Extensions to the amount of patients Level 1 and 2 GPs can treat.

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20		Traveller Specific Drugs Initiative, Pavee Point Travellers Centre	Cultural awareness training for Level 1 and 2 GPs to assist with the treatment of ethnic groups, including Travellers. This could be facilitated by the ICCPE and various national support agencies for minority ethnic groups. GPs with an increased awareness of specific issues affecting their Traveller clients can take this knowledge into consideration when jointly drawing up treatment care plans; increasing the likelihood of adherence to treatment regimes.
26		SAOL Project	Communication issue between clients and doctors. The power relationship between doctor and client is, as a rule, very one sided. However in an addiction setting, this relationship is even more sensitive and doctors need to be cognisant of this in their dealings with clients. Some in service training days facilitated by ex service users and focusing on their experiences might be of benefit here.
27	Dr John Moloney		Training up Level 1 and Level 2 GPs. I believe that the Addiction Centres provide a terrific location and a friendly environment for an interested doctor to sit-in with a colleague and see a wide range of cases and how they are managed. He or she will also get a sense of what type of patient would benefit from a more structured environment in a clinic and who does well in a community setting. Consideration might be given to utilising this training resource.
29		HSE Addiction Services Dublin North Central and Dublin North	Enrolment of GPs. An information leaflet needs to be developed for all surgeries nationally providing information on how to enrol on the scheme, who to contact and contact details. Consideration should be given to employing a person in a PR capacity to promote the scheme and whose responsibility is to motivate GPs and increase enrolment to the MTP.
			Training of GPs. Training needs to be mandatory in certain DED. areas as part of GMS list contracts. To target training for specific surgeries in specific areas. GPs need to have access to training in brief interventions, motivational interviewing/enhancement approached, relapse prevention, comprehensive assessments and key components of care planning. There should be ongoing training/annual conferences. The self-care of GPs to avoid burnout is an essential component of training for addiction work.
			Level 1 & 2 GP Training. There needs to be a review of the existing training programme. Level 1 GPs need to have access to ongoing supervision and mentoring in relation to the management of cases.
			GP Co-ordinator role. The GP Co-ordinator needs to have a clinical governance role and a formalised line management relationship with Level 1 and Level 2 GPs in the community as a national standard. They should have clinical and administrative responsibility for training, supervision and mentoring. Should be a set number of meetings a year for review of cases and supervision.
30		Soilse - Service Users	GP Roles. Comments generally critical and relations poor - concerns expressed over doctors' control and power, and lack of co-operation. Visits can be a formality where boxes are ticked and paperwork done - just doing job/ what is best for pocket. Care is lacking and there is a disinterest from the doctors. Not aware of the psychology of recovery
			Unaware of the position and role of the GP Co-ordinator
31		SOILSE - Staff	Every GP in Ireland should take methadone clients. This should be part of their employment contract as should Care Planning, case management and interagency co-operation around clients. This also presents a mandatory training requirement.
			All GP's, Level I and Level II should be encouraged to work in teams. They should receive mentoring and supervision. Numbers should be of a realistic level to ensure the process is quality proofed (Care Plans are effective and integrated).
			GP Co-ordinators roles: should operate to a) to mentor GP's at Level I and II b) supervise GP's at Level I and II c) facilitate interagency co-operation d) audit Care Plans e) ensure training, particularly CPD is in line with a basic competency framework, to enable high quality progression and patient advocacy.
			Problem of 'conveyor belt medicine'. An ongoing concern in Soilse is what has been described as conveyor belt medicine where the level of care is minimal and script based, the medical model being primary at the expense of any social dimension or awareness of complementary services. Indeed a Soilse Internal Survey (2010) of 35 recovering drug users found not one doctor had enquired as to their satisfaction of the service they receive. Possibly doctors are sceptical of responses beyond their control, working in a medical hegemony.
33	Dr Colm Quinn		Level 1 & 2 GP criteria. I am not wholly convinced of the distinction between these two categories and find it somewhat arbitrary. I have no problem with recruitment of new patients being limited to more experienced methadone prescribers but I find outside Dublin e.g.. Waterford where we have 25 patients and a Waiting List of 40 that there are overly restrictive conditions in transferring patients (whom I think suitable) to a Level I community GP who is already prescribing methadone.
35	Dr Paul Quigley	Addiction Service HSE Dublin North East	Varying interpretation of the GP-Co-ordinator role and lack of co-ordination among co-ordinators. Boundaries and scope of the role is unclear.
			Stifling of natural discourse between clinic medical staff and GPs in the community. GP Co-ordinators need to promote positive working relationships and possess excellent communication skills, or be willing to invest time to develop these skills. Silo working is contrary to HSE policy and good governance.

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37	Dr Declan O'Brien & Dr Don Coffey		Specialist Nurse Practitioners. We welcome the introduction or specialist Nurse practitioners in Dublin and hope this specialist will become a national entity.
			Enrolment of GPs, particularly those in single handed practice is difficult and our experience is that it can take up to 3 months to get approval as a level 1 GP. Without accreditation it is almost impossible to become a level 2 GP outside of the Dublin area. We think a more flexible definition of what a GP is indicated.
			Outside of the ERHA area more doctors are needed and we feel a more flexible contract may be appropriate in these circumstances. Indeed it may be appropriate for this review group to visit the 'provinces' to get a fuller understanding of these issues.
40		Irish Medical Organisation	Level 1 GP training and recruitment. Whereas GPs are generally aware of the training available to them via the ICGP for the provision of services under a Level 1 Contract, only a portion are actively involved in the provision of services in this regard. A database of all trained GPs and the number of patients currently being managed by each GP, as well as the number of patients that GP is willing to take on would be a useful resource to GP Co-ordinators and level 2 GPs to ensure this valuable resource is used efficiently.
			The major barrier to methadone treatment in centres outside Dublin is the lack of treatment centres or adequate numbers of Level 2 GPs to assess initiate and stabilise methadone treatment for opioid dependent people. Increasing the number of Level 1 GPs does little to increase the number of patients in treatment as these Doctors cannot start new patients. Therefore the number of Level 2 GPs in outlying areas needs to be increased either by allowing experienced Doctors (trained in the HSE clinic system) to provide Level 2 services, even provisionally pending an audit, or by allowing existing Level 2 GPs to provide services in more than one location or to more than 35 patients.
			Provisional GP Level 2 Status. The ICGP on their website until May of this year had special recognitions of the training and experience that a GP may have obtained through working in a HSE Addiction Service clinic and, as such, could offer 'Provisional Level 2 status' subject to an audit after 6 months working in this capacity with restricted numbers of patients. This provision has since been removed and a GP is required to 'operate as a Level 1 GP until an audit is performed after 6 months' regardless of their level of experience or training.
41		FSN	GP Training. The importance of family and service user involvement should be emphasised in GP training and GPs should be asked when enrolling their viewpoint on this issue.
43		Ballyfermot Advance	Integrated services. Clients transferred from addiction centres to GPs tend to receive no ancillary or supplementary services outside of the methadone/medication provided by the GP. This is insufficient to meet client needs. The GP must be responsible for the patient's well-being and overall medical condition - GPs who do not have sufficient resources within their practices to deal effectively with drug users should be excluded from enrolment.
			Clients feel that GP's must be made responsible and accountable for their client's medical well-being and not just be 'prescribing' doctors; and say that people on methadone are treated differently than other patients.
			There is a lack of supervision of clients receiving treatment from community GPs and there may be a sense that this leads to methadone leakage on the streets.
			Lack of supervision of clients receiving treatment from community GPs and there may be a sense that this leads to methadone leakage on the streets.
			Employment of addiction key workers or other professionals on a part-time basis within GP setting to do attend to the additional needs of the drug user.
46		Drug Treatment Centre Board	The online training measure for GPs introduced by the ICGP coupled with the input by GP Co-ordinators has led to an increase in the number of GP's engaged in the provision of treatment services. We recommend this be continued.
49	Dr Desmond Crowley		Extending GP numbers. Serious consideration should to given to extended the level 1 and level 2 numbers along with freeing up GP coordinator time to allow the development and support of primary care.
50		Consultants in Substance Misuse	Increasing GP participation in the protocol. Local support from Substance Misuse services under the direction of a Consultant Psychiatrist would encourage more GPs to participate in the protocol. A local GP co-ordinator would similarly be of benefit (rather than one national coordinator).
			GP role above just methadone prescribing. GPs providing methadone treatment should also provide general medical care to their patients rather than allowing the proliferation of 'methadone only doctors' in a primary care setting.
			Training in brief interventions, motivational interviewing etc needs to be ongoing for level 1 and 2 GPs. Existing training needs to be reviewed and a clearly defined ongoing training programme needs to be put in place and resourced.
			GP patient numbers. The numbers of patients attending level 1 and 2 GPs needs to be reviewed upwards perhaps to 25 patients for level 1 and 50 patients for level 2, however there needs to be a requirement for level 2 GPs to transfer patients to level 1 once stability has been achieved. In large group practices there should be a mix of level 1 and 2 GPs. All GPs on the methadone treatment protocol should be on the specialty register for General Practice.

Sub. ID	Source if individual	Organisation	Submission
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Lack of knowledge of how to engage in the MTP has restricted treatment places in the past. Recommend that standard information packages be supplied by ICGP to all GPs nationwide with names and contact numbers of GP Co-ordinators, liaison pharmacists and drug co-ordinators for the different regions.
			Roles of GP Co-ordinators and Chief/Liaison Pharmacists have been central to service development. Both roles are valuable in maintaining standards and confirmation of practice with best practice and with legal requirements.
			Availability of Level 1 training to community pharmacists should be re-instated, it is a valuable tool, especially to community pharmacists outside of Dublin, for increasing access and improving service quality.
			Accredited addiction training should be mandatory for both GPs and community pharmacists operating under the MTP, and on a regular basis to establish standards of care.
			More training for community pharmacists. Training for pharmacists is delivered by the Irish Centre for Continuing Pharmacy Education (ICCPE) every two years in several locations nationally. Training should be made available more frequently with accreditation on a similar basis to the training offered to GPs.
54	Dr Patrick Troy		Failure of recruitment of GPs in the rural setting is caused by individual rural GPs having very few drug addicts and seeking to 'off load' them for treatment to a clinic setting. By not partaking in training they do not have to treat them in future; they are reluctant to have drug addicts in their surgeries due to past experiences or current day antipathy to drug addicts. They cite potential violence, prescribing pressure, threats to staff as reasons for not taking the addicts back into treatment in their surgeries, much of these fears are misguided. The HSE has few structures to offer support in times of crisis in rural areas, unlike in the Dublin setting. The GPs have little contact with the local drug addiction services and little confidence in the support that is promised by the HSE e.g. treating aggressive/violent individuals.
			Local GP Co-ordinators have a role in facilitating the recruitment of GPs. They can liaise with the clinics and the GPs in the community to explain the service, offer support and education, and attend local ICGP meetings. Liaison with local pharmacies is also vital to ensure their ongoing support as there are no dispensing clinics outside Dublin. A national GP Co-ordinator cannot offer such local services and interference from Dublin may be considered a hindrance by rural GPs.
55		South Western Regional Drugs Task Force	Existing approach is limiting the involvement of GPs. Consideration should be given to extra levels of involvement such as those GPs that are committed to working with community and voluntary groups via interagency proto-cols.; those GPs that are part of a Primary Care Team with extra psychosocial supports.
			Level 2 GPs with many years of experience could provide prescription mentioning to GP practices across the country.
			Current Level 1 and 2 conditions and training should be independently reviewed and evaluated in order to increase GP involvement.
			Introduction of new Level 3 status for GPs with 5 years experience and audit, to operate under the auspices of Primary Care Teams with support from community based addiction services. This GP could feed service users to Level 1 GPs with support from local addiction services in the community within a local 4 way agreement model between GP, community pharmacy, community addiction services and the client.
56		Citywide	GP Training. Clinical training for participating level 1 & 2 GP's should include training inputs covering the role of community projects in case management and the supports projects can offer to GP's/Clinics. It should also include input from clients about their positive and negative experiences of methadone treatment so that more patient-centred services develop.
			GP engagement with local projects. Local and Regional Drug Task Forces should co-ordinate regular meetings with participating GP's and local projects to establish an interface. All participating GPs and projects should be obliged to engage in such meetings with terms of reference negotiated and agreed.
57		Tallaght Local Drugs Task Force	GP Training: Add community input to training, to create holistic picture of patient in their community and the impact of drug use and treatment on the patient, family and community. Also, education on drugs, motivational interviewing and cognitive behavioural therapy. Finally, drug users and ex drug users should be invited to training to present their personal and individual experiences as drug users and as patients.
			GP Enrolment: Protocols should be designed and developed for unstable clients with private GPs to be referred back to community clinics. Private GPs could benefit from the accountable framework attached to the metha-done protocol, e.g. addiction services team clinical supervision. Support structure developed in areas to encour-age and advance GP enrolment in local communities.
59		Jobstown As-sisting Drugs Dependency Project Ltd	Chaotic drug users: Are GPs and methadone prescribing doctors sufficiently well trained to identify and respond to chaotic polydrug use?
60		Irish Associa-tion of Alcohol and Addiction Counsellors	All level 1 and 2 GPs should receive information on local drugs services to support their work.

Sub. ID	Source if individual	Organisation	Submission
61		North Dublin City and County Regional Drugs Task Force	False perception of long waiting times in region may act as a deterrent for accessing and availing of treatment.
			Ongoing support, information and training for GPs and pharmacists are required.
			GP patient numbers are capped - experienced GPs could be in a position to take on a larger number of clients if monitored and supported.
65		Medical Staff Committee, Addiction Services HSE Dublin North East	Links between clinics and GPs. Patient transfer to GP prescribing can be slow. Complex issues may emerge and transfer back to a dispensing facility may be necessary. Level 1 and 2 GPs sometimes complain to us of feeling unsupported, and of having poor access to counselling services. Much better medical networking is needed.
			GP Training. We have concerns that some GPs have Level 1 training without any practical exposure to the complexities of addiction. There is a lack of transparency about the process of Level 2 training and accreditation. We advise that the ICGP should develop much better links with HSE clinic staff in this regard.
			Role of GP Co-ordinator. There is a lack of clarity with regards to this role and around working relationships between clinic medical staff and co-ordinators. We are discussing the issue on an ongoing basis.
			Obstacles to Level 2 status. The ICGP no longer offer 'Provisional Level 2 status' to GPs with experience and training obtained through working in HSE Addiction Service clinics for more than 1 year. Special recognition of experience gained in HSE Addiction Services clinics should be reinstated and that doctors in this position should be in a position to obtain Level 2 contracts and thus be able to assess, initiate and stabilise patients in the community.
66		HSE Social Inclusion	Increasing GP patient caps. We are keen that the review re-examines the rationale and evidence to continue with the present cap on the number of patients for Level 1 and Level 2 GPs.
			Need for GP Co-ordinators. The role of GP Co-ordinators and whether this is an optimal use of expertise and clinical training, given the emergence of clinical directors, is another matter that is timely to review.
67		HSE Addiction Services Medical Staff	The major barrier to methadone treatment in locations outside Dublin is the lack of either treatment centres or adequate numbers of level 2 GPs to assess, initiate and stabilise methadone treatment for opioid dependent people. Level 1 doctors cannot start new patients.
			We are of the opinion that the special recognition of experience gained in HSE Addiction Services clinics should be reinstated and that doctors in this position should be in a position to obtain level 2 contracts and thus be able to assess, initiate and stabilise patients in the community.
			GP Coordinator Role: A local GP coordinator sets up referral pathways, educates, supports and encourages local GPs to become involved in the treatment of their patients. The coordinator also has a role in supporting and educating pharmacists. There are no GP coordinators outside of Dublin. The introduction of local GP coordinators throughout the country is necessary.
68		Irish College of General Practitioners	Review the role of the GP Co-ordinator. The GP Co-ordinators are contracted by the HSE. One of the functions of the GP Co-ordinator is to provide a link between the HSE clinic services and the community GPs. Through feedback from the GPs participating in the audit, the ICGP understand that some GPs do not feel supported in their role by the GP Co-ordinator. The ICGP believes that GP Co-ordinators could take a more proactive role in recruiting interested GPs to participate in the MTP and should be available to support the GPs.

5. To review the MTP with regard to urinalysis testing; its appropriateness and efficacy

Sub. ID	Source if individual	Organisation	Submission
1	Dr Garrett McGovern		Review in relation to best practice. The international evidence does not support regular (i.e. weekly) urine testing, which is also prohibitively expensive. In some centres doses are reduced in response to 'positive tests' and this also runs counter to international best practice. The frequency of urine testing should be at the discretion of the prescribing doctor and urine results should never be used punitively.
2		Addiction Services Dublin Mid-Leinster South Western Region	There should be a standardised approach to the issue of urinalysis in GP practice nationally. There is some inconsistency in relation to taking of samples and in some cases this is leading to unnecessary laboratory costs. Unequivocal directions would be helpful in this regard.
			Look to international best practice. Consideration should be given to the international evidence for the most appropriate level of urinalysis to be implemented in GP practice. Consideration should also be given to other models of drug testing.
7		CARP Killinarden	If urinalysis is obligatory a person has the right to decline on the condition that they are on daily supervised dosages.
16		Bray Local Drugs Task Force	Urinalysis can support the individual in their treatment. It can provide a measure of an individual's progression in treatment, it can be a psychological support , and it can bring an element of routine into an individual's life that maybe has been missing for some time.
17		OMD	Reduced screening. The OMD is of the view of that the frequency of screening for clients, particularly those clients that have been stable for a long period, should be reduced given the significant costs involved that could be put to better use. Randomised testing might be involved in such cases to reduce the risk of abuse.
18		Northern Area Voluntary Cluster and Dublin North Inner City Drugs Task Force (submissions received separately, merged here due to crossover of themes)	Urinalysis should be replaced with mouth swabs and should be randomised. This would aim towards providing greater dignity for service users. Randomisation would also be likely to provide more accurate estimates of drug use. Although the ability of an individual to request additional weekly/twice weekly testing should also be facilitated.
			Guidance for clinics that urinalysis will be provided on request. Provision should be made that on the request of a service user, urinalysis can be weekly and also that results can be sent to community and voluntary treatment providers, with consent from the service user.
			Urinalysis provisions for rehabilitation service entry. In some cases where an individual has completed methadone treatment and is awaiting entry into a rehabilitation service, it can be difficult to secure the required urinalysis results. It is recommended that provision be made for an individual who needs to return to a clinic for urinalysis that is intended for entry into in a rehabilitation programme.
19		Rialto Rights in Action	The practice of urine sampling is degrading. Urine sampling in the manner which it is currently conducted is not necessary, of poor quality, unreliable and a gross violation of the dignity of people and a violation of human rights. This practice should be brought to an end immediately.
23	Deirdre Carmody, Drug Liaison Midwife		Urinalysis and pregnancy. In my experience social workers in the community put great emphasis on urine toxicology, be it good or bad. I find a good few women persistently refuse to give urines during their pregnancy in the methadone clinic.
26		SAOL Project	Supervised urine collection is dehumanising, embarrassing and degrading, as reported by clients. Alternative drug screening options should be available where the State cannot provide even a basic level of privacy to clients - such as mouth swabs and hair samples.
27	Dr John Moloney		Urinalysis is useful but limited. I believe that urinalysis has an important role to play in establishing the drug-stability of a patient for positive contingency management. It is also important to know what other drugs a patient is taking, particularly drugs which have arhythmogenic properties or which affect the QT interval of the patient. On the other hand I believe that the cost of urinalysis , as currently structured is excessive (Claymon Laboratories plus Trinity Court Laboratory) and that all urinalysis should be transferred to one centre (Trinity Court).
			Clinicians should have greater input into what tests are routinely ordered. The current profile provided by Claymon repeatedly tests for drugs which have a long half-life (e.g. benzodiazepines) at short intervals or which are rarely encountered at present (Amphetamines). The samples are collected more frequently than is necessary and their computerised results are not user friendly. This is expensive and perhaps not cost effective. Clinicians should have a say in what tests are carried out by the laboratory

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29		HSE Addiction Services Dublin North Central and Dublin North	Test kit types. All urinalysis should ensure measurement of EDDP. Non availability of testing for z-hypnotics needs to be addressed.
			Frequency of testing. Need a frequency of urinalysis based on best evidenced practice agreed by a national group comprising HSE and Primary Care; for the current practice of weekly urinalysis for all service users regardless of level of stability to be reviewed; and to define treatment programmes and correlate the frequency of urinalysis depending on the programme.
			National standards need to be established to ensure appropriate chain of custody of urine samples to a laboratory for urinalysis
			Need for standardisation in supervising urine sampling
			Budget for urinalysis needs to be defined. Need an allocation for urinalysis i.e. Addiction Services or Primary Care.
			Onsite/lab testing. A review needed of on site dipping as a possible alternative to lab testing, from cost effectiveness (50% possible within existing frameworks). Also, a need to identify exceptions where laboratory testing is required including childcare, court appearances etc. If onsite testing, need to agree uniformity of testing kits.
30		Soilse - Service Users	Pros: Very helpful when trying to get clean; keeps you on track
			Cons: At first it is very embarrassing; not nice having someone standing over you and sometimes you can't go because of this. No way of telling apart heroin vs. painkillers - if positive, just assume you have used heroin. No alternatives offered - such as mouth swabs, hair or temperature bottles. Easy to give bogies, especially for men.
31		SOILSE - Staff	Uniform standards on screens to ensure patient dignity enforced. Standards for drug screens should be uniform to ensure the service user is at all times treated with dignity, in appropriate facilities. Also more dignified alternatives should be considered (swabs / hair). Screens are essential for detoxification preparation and consolidating recovery.
			Screens should be used to positively reinforce service users progression. Screens should mandatory test for alcohol and other substances for those on methadone, with "purposeful sanctions" for positive screens being evoked (CBT / Relapse Prevention / MIT/ BIT / Care Planning). Otherwise it is a waste of money.
			Service user requests for screens. Where former service users require access to drug screens to validate progression, this should be provided.
			Validation from service users should be sought. An audit of services users should occur as to determine the appropriateness and effectiveness of drug screens. In Soilse service users have consistently viewed them as highly useful over the years empowering them to take increased responsibility and ownership of their recovery.
34		McGarry House	Clarity needed around the purpose and effectiveness of urinalysis. Should testing only take in opiate based substances? For most of our poly drug users this is almost always ineffective as opiates are often substituted with other substances
35	Dr Paul Quigley	Addiction Service HSE Dublin North East	There is a broad consensus on the need to reduce the frequency of urine testing.
37	Dr Declan O'Brien & Dr Don Coffey		Limited usefulness. We recognise the limitation of urine screening and agree that its place must always be along side clinical examination and not instead of it. A relationship of trust can be difficult with a patient if urine screening is mandatory as part of a protocol and in a situation where use is admitted by a client it may indeed be a waste of scarce resources.
38	Aaron Keegan	Euromedic Lablink	Need for a public tender procedure for this service. The review should investigate the value for money received from private pathology testing and whether new testing protocols, improved ICT facilities, standard testing profiles and improved public sector capacity will allow more scarce resources to be allocated towards key clinical pathways.
40		Irish Medical Organisation	Based on the available evidence, IMO GPs recommend a review of the frequency of urinalysis testing. Resources currently being wastefully expended in this area could be better used to provide treatment to presently excluded populations.
41		FSN	Alternative options needed. System at present is inhumane. Other options need to be tried, e.g. mouth swabs and hair analysis, and these should be conducted at random.
			Results should be discussed with drug users and looked at in a holistic manner to see if problems have arisen for users which they need support with, rather than as a punitive mechanism.

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43		Ballyfermot Advance	Alternatives to urine sampling such as saliva testing would be more appropriate, safer, less intrusive and more foolproof. Options should be made available to clients who suffer from 'stage fright'.
			Clients who are wrongly accused of giving 'dirty' samples should be given automatic, independent testing.
			Community-based testing must be supported for those attempting detox or stabilisation within their own communities, as often this service is not available to community projects.
			Where testing results are required for entry to residential rehabilitation this creates a barrier to progression for the client.
44		Clondalkin Local Drugs Task Force	More dignified and client-centred methods needed for drug screening.
45		GPSSA Education Committee	Review of the role of toxicology screening in treating opioid dependence.
46		Drug Treatment Centre Board	Urine is the sample of choice for screening of drugs of abuse in that it has a longer window of detection and therefore supports randomized screening. Methods are well developed and validated; Quality control measures and proficiency testing schemes for drugs in urine are well established; This type of testing includes the metabolite of Methadone (EDDP) which identifies adulteration by Methadone; Methods developed to support the measurement of levels and identification of specific drugs i.e. benzodiazepine identification; Methadone levels can be measured to support the appropriate clinical management of clients on triple therapy treatment; Is inexpensive, can be undertaken in house and as such has the flexibility to respond to changes in requirements for screening of specific drugs; Methods developed for confirmatory analysis to support legally defensible requirements (i.e. fitness to practice, employment assistance programmes and court orders) and national trend analysis which includes new drugs both prescribed and illegal as well as head shop products; Supports service planning; Allows for historical collation of data for research which can be input into the client's electronic patient record in real time.
			Urinalysis forms part of a care plan for the treatment of addiction giving objective evidence of treatment outcome. It is essential for assessment as precursor for treatment. It supports clinicians in ongoing monitoring for compliance and provides objective evidence of behavioural change for clinicians and clients. It is a measurement for contingency management regimes.
			The frequency of testing for clients should be regular enough to support compliance with their agreed plan of care i.e. compliance with methadone treatment and abstinence of use of non prescribed or illicit drug use. The half life of some drugs is variable ranging from as little as 24 hours. This may not be captured through infrequent sampling.
			Hair sampling: Analysis is very time consuming, specialized and there are issues such as external contamination of hair; Can give a historical picture over time but not the most suitable for randomized testing; Extremely expensive (circa €180 per sample) and not carried out in Ireland.
			Saliva testing: Drug levels in saliva are low with a short time window; Validation methods not well developed as in urine; Samples can be time consuming to take (due to dry mouth caused by drug use or contamination of mouth which may affect results) and can involve a significant amount of staff time for supervision; There are a wide range of saliva collection devices and no universal standards; Proficiency testing still in its infancy; Saliva testing kits not developed for any new drugs whereas urine samples can be tested by a range of techniques; Difficult to collect from those abusing stimulants such as cocaine and ecstasy; Low concentrations make detection difficult and necessitate expensive equipment (LCMS).
			Dip stick testing has limitations. There may be a role for these in the more stable cohort of clients. However, interpretation can vary hugely and a comprehensive training programme would need to be put in place to support this further.
			Point of care testing: Kits are subject to interpretation in their use; They are variable in their false positive and false negative rates; Quality control is largely absent (PT schemes); They are expensive; Data collection is not in a form transmissible to patient systems and while results are instant, reports are not readily available; No new drugs are covered by point of care testing (e.g. head shop drugs or new to market).
48		Kilbarrack Coast Community Programme	We question the accuracy of urinalysis and believe there is widespread abuse. Alternatives, such as mouth swabs is suggested.
			Collection of urines is undignified and militates against the building up of positive relationships

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49	Dr Desmond Crowley		High costs. In our service we have an excessively high volume of external lab based urinalysis. This is costly and I question the appropriateness in clinical management. Most treatment providers are not sanctioning for opiate positive.
			Limitations. Urinalysis is an effective tool in assessment but there is a problem with double testing especially in the prison service. (Dipping on site followed by lab testing). Urinalysis is useful for supporting drug stability, for analysis of trends, for identifying substance of abuse; however the weakness in not identifying zimovane use or many of the non-amphetamine based newer drugs "Legal highs". Also, it is not qualitative. I would suggest an alternative of on-sight dipping with temperature jars.
			There should be a national consensus on frequency (committee) with identified exceptions e.g. child care/ court legal/ if patient disputes result and as a way of ensuring accuracy of on-site dipping. Even with no reduction in frequency this would lead to an immediate reduction by 50% in costs. There should be a review of lab at Trinity Court looking at its cost effectiveness and the necessity for city centre location and its capacity and its role if urinalysis were to be performed locally.
			There should be a uniform testing kit nationally to avoid huge variations.
50		Consultants in Substance Misuse	Test type. Urinalysis should ensure measurement of EDDP to monitor for diversion of methadone and all dipsticks need to include this facility. Prior to commencement of treatment at least one sample should have laboratory confirmation.
			Benefits of urinalysis. Urinalysis is an essential objective tool for the clinician to monitor the effectiveness of their treatment intervention. It is essential for safety in terms of monitoring compliance and to monitor the use of other substances. Urinalysis is also vitally important in the area of contingency management and the provision of takeaway doses of methadone. The results provide valuable information to be used for motivational interviewing and review of treatment goals and care plans. A paper earlier this year in the BMJ among a cohort of 2378 methadone patients attending primary care identified that a history of involvement in urine testing programmes was a protective factor in relation to all cause mortality (McCowan, Kidd and Fahy, 2010). Clearly opiate use is associated with decreased methadone adherence (Raffa et al, 2007). In addition the provision of regular urinalysis can have important impacts on Court Reports, Social Services Reports and entry into rehabilitation programmes in that they allow the clinician to provide objective clinical evidence in relation to the stability and progress of an individual on Methadone treatment. Urinalysis is also essential to monitor drug interactions as use of cocaine may have implications for prolonged QTc intervals particularly for those patients on higher doses of methadone or in receipt of Antiretroviral therapy.
			Testing frequency. We consider that regular weekly urinalysis is essential for all patients on methadone treatment. Any move to less frequent testing should only occur in patients who have been completely stable for 1 year and even then this should be randomised to once a fortnight and no less.
			Additional ECG monitoring. In addition requirements need to be put in place for ECG monitoring. This should be mandatory for all patients commencing on methadone and for all patients on higher doses of methadone. Regular repeat ECGs need to occur annually.
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Various models of drug testing should be reviewed and evaluated. Based on these results there should be direction provided detailing best practices regarding frequency of testing and that chain of custody etc, be standardised nationwide and protocols put in place. The HSE Northern Area Pharmacy department has carried out a clinical audit on the Frequency and cost of Urinalysis whose recommendations suggest a change in practice and a standardisation of service provision.
			Provision of testing utensils and cost analysis needs to be reviewed by the HSE. There are discrepancies in the provision of such equipment to Level 1 and Level 2 GPs nationally.
			Provision of equipment to community pharmacists needs review. The cost of packaging material for takeaway doses of methadone has limited the adoption of best practice in packing each dose separately to aid compliance.
55		South Western Regional Drugs Task Force	In many areas urinalysis is used as a punitive measure.
			Supervision not consistent. Supervised urinalysis is common in clinics but not in GP surgeries due to the time and costs involved.
			Does not highlight progression. Urinalysis can identify the presence of substances in the system but not highlight progression i.e. from daily use to weekly use, etc.
			Outdated, invasive and expensive procedure that should be examined on the implications of how it impacts service user's psychologically, and also value for money in relation to its objectives. Alternatives are available and could be done on a spot-check basis.
			Undermines the GP-patient relationship and is not conducive for a positive therapeutic relationship.
56		Citywide	Degrading methods. Observing the client by standing in the cubicle is degrading and its practice should be discontinued. Knowing the drug status of clients is essential, there are many alternative tests to determine drug use available (inc mouth swabs) and we suggest phasing out urinalysis in favour of these.

Sub. ID	Source if individual	Organisation	Submission
57		Tallaght Local Drugs Task Force	Random, discretionary urine testing is sufficient and a better use of resources, as modelled in other countries.
			Those interested in residential treatment should be accommodated with additional urine testing.
61		North Dublin City and County Regional Drugs Task Force	Urinalysis has a place in treatment in terms of accountability however other less invasive possibilities could be explored - such as hair, fingerprints and saliva swabs
63		UISCE	Alternatives to urine sampling needed, such as mouth swabs.
			Frequency of testing need to be examined. Frequent testing should not be wasted on someone who is consistently "clean", or for someone who is equally consistently "dirty".
65		Medical Staff Committee, Addiction Services HSE Dublin North East	Broad consensus that too much resources are expended on urinalysis.
66		HSE Social Inclusion	Method and frequency issue. The present approach to drug testing, specifically the method and frequency utilised, is an issue which has generated much discussion and debate amongst both service users and staff in the addiction services.
67		HSE Addiction Services Medical Staff	Recommend a review of the frequency of urinalysis testing in light of the evidence around this area. Resources currently being wastefully expended in this area could be better used to provide treatment to presently excluded populations. Alternatives, such as oral fluid point of care testing should also be examined.

6. To engage with the Department of Justice with regard to the prescribing of Methadone in Garda Stations

Sub. ID	Source if individual	Organisation	Submission
1	Dr Garrett McGovern		Drug users in Garda custody. The treatment of drug users arrested by the Gardai is less than ideal. More often than not drug users are left without any treatment for the duration of their arrest. Gardai are slow to contact treatment providers. The training of Garda GPs in drug treatment is poor and needs to be improved.
2		Addiction Services Dublin Mid-Leinster South Western Region	Clear protocol with Level 1 GP training a minimum. There should be a clear protocol in relation to the provision of methadone in the Criminal Justice System. Garda Doctors should be trained to at least Level 1 to ensure best practice in the provision of methadone to individuals in Garda Custody.
7		CARP Killinarden	Mandatory urine screens for people in detention and/or Garda custody who claim they are in receipt of methadone before receiving methadone.
			Record keeping. For people in methadone treatment taken into custody a written record should be kept as to when they were taken into custody and when they requested methadone and when they receive it.
8		Irish Pharmacy Union	Review of methadone supply to patients in Garda custody. Community pharmacists experience problems around the supply of methadone to patients in Garda custody. The guidelines around this are not straightforward and need to be reviewed immediately. When patients participating in the scheme are release there is currently no forewarning to the community pharmacist they regularly attend, which creates problems when trying to verify whether a dose was or was not given while in custody.
9	John Craven	Dun Laoghaire Rathdown Local Drugs Task Force	Protocol should be extended to Garda stations to govern the administration or methadone to people in custody through a properly resourced forensic service.
17		OMD	Protocol development needed. OMD supports the improvement to procedures in this regard. No guidelines are in place at present and we feel that there is a need to formulate a protocol with a view to maximising the chances for effective service provision, while minimising the risks involved.
29		HSE Addiction Services Dublin North Central and Dublin North	National standardised protocols needed for doctors treating drug users in custody, outlining how to treat withdrawals, to induct on methadone and to prescribe an ongoing methadone maintenance programme. Standardised training to accompany for all doctors attending Garda Stations. This needs to have a time defined for implementation.
			CTL out of hours access. Doctors need access to central treatment list out of hours.
30		Soilse - Service Users	Presence of a doctors. At weekends there is no doctor available in some stations. You could sometimes wait up to 24hours. A doctor should be assigned to Garda stations in areas where there is high prevalence of drug use. A doctor should have access to records (on methadone or not).
			Key workers. In the UK when someone is brought into custody and are addicted, a key worker is assigned to assess their mental state and to access methadone/access to a doctor arranged. This is done in the first hour of being detained and before any interviews are done and is a confidential service. The same should occur in Ireland.
			Punitive use of methadone. In some stations, Garda hold your methadone use over you and use it as a threat. It is given at the Garda discretion. In some stations you are given 20mls to hold you.
31		SOILSE - Staff	There should be a standard protocol for the prescribing of methadone for people arrested in gardaí stations. This must not be subject to abuse by the gardaí and should be overseen by the Ombudsman for the gardaí
34		McGarry House	Garda training around methadone prescribing with procedures in place for those who are in methadone treatment if they are arrested needed.
37	Dr Declan O'Brien & Dr Don Coffey		Access to medication in Custody problematic. While the protocol was initially designed to allow the methadone follow the patient we are still finding that clients have problems accessing their medication in secondary care and while in Custody.
			Liaison with Dept of Justice needs to be ongoing. We welcome the Prison Service policy of having Methadone available to prisoners, but methadone is still not available in all prisons. There are health and safety issues in giving methadone to those in short term Garda Custody, but those in custody longer than 24 hours should have access to their medications. Initiation of Methadone should generally not occur the acute arrest Situation
40		Irish Medical Organisation	Clear guidance and training in the provision of treatment to opioid and other drug dependent people who are in Garda custody are essential.
			The IMO is of the view that the establishment of a properly funded and staffed forensic medical services would be the most appropriate manner through which to deliver care to this vulnerable population.
43		Ballyfermot Advance	Dedicated 'in-cell' addiction workers need to be made available within the community that could be called upon, during arrest, to assist in addressing the needs of the individual in conjunction with the prescribing doctor.
46		Drug Treatment Centre Board	Need for protocols and structures to be developed for methadone prescribing in Garda stations which are underpinned by clear governance structures. In addiction clear procedures are training should be developed.
			Doctors providing this service should be Level 2 GPs and treatment carried out should be reported to the CTL.

Sub. ID	Source if individual	Organisation	Submission
49	Dr Desmond Crowley		Protocol needed. A clear protocol should be established for the safe dispensing of Methadone to patients while in Garda custody. The same standards as the IPS services both of the continuation of MMT and for symptomatic opiate withdrawals.
			Other meds. A perfect environment for suboxone or buprenorphine (which is much safer in overdose) and we should also review of the inappropriate prescribing of benzos, Librium and hypnotics in the management of possible withdrawals.
50		Consultants in Substance Misuse	Garda Doctor protocols and competences. Garda doctors need to have clear protocols in place for the provision of methadone to prisoners in custody. They should have specific training in Substance Misuse and consideration should be given to training up to a level 2 GP status. They should link in with ongoing CPD and training in the substance misuse services. Access to the Central Treatment list out of hours at weekends needs to be available.
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Lack of consistency in prescribing of methadone to patients in custody nationally. A national policy needs to be developed in conjunction with the Department of Justice and that direction is required to ensure safe provision of methadone in this instance.
			GPs providing medical services through the Dept of Justice to patients in Garda custody should receive Level 2 GP training.
57		Tallaght Local Drugs Task Force	Enhance co-operation between relevant agencies - Gardai to be supported and facilitated in finding out whether a client is in treatment.
			Review methadone prescribing in custody for people with a heroin problem and/or on methadone
61		North Dublin City and County Regional Drugs Task Force	Governance and clear policy required for methadone prescribing in Garda stations.
			Level 1 or 2 GPs required rather than GPs on duty at a particular time of intervention.
			Will clients be court ordered to attend stations for treatment? Stigma may be encountered.
65		Medical Staff Committee, Addiction Services HSE Dublin North East	The Garda Siochana should adopt the policy of the Irish Prisons Service in relation to the safe prescribing of methadone for those who develop opiate withdrawal while in custody.
67		HSE Addiction Services Medical Staff	Clear guidance and training in the provision of treatment to opioid and other drug dependent people who are in Garda custody are essential. In the absence of such a service GPs working for HSE Addiction Services would welcome the opportunity to provide input to the development of appropriate guidelines. We have developed draft guidelines in this regard.
			A properly funded and staffed forensic medical service would be the most appropriate manner through which to deliver care to this vulnerable population.
69		Dept. of Justice and Law Reform	The treatment of persons detained in Garda custody is governed by the Criminal Justice Act 1984 (Treatment of Offenders in Custody in Garda Stations) Regulations 1987, as amended by SI No.641/2006); Regulation 21 addresses the issue of medical treatment. The operating premise is that the provision of medical treatment to a person in custody should, insofar as possible, be equivalent to that provided outside of custody with only those modifications necessitated by circumstances.
			The Garda role in medical treatment of persons in custody is limited to: arranging treatment provision; recording certain matters and complying with instructions given by the doctor in relation to the care of that person. Any enquiries into the doctor/patient relationship by the Garda Siochana are kept to an absolute minimum.
			The practice is for each Garda Station that processes arrested/detained persons to have a list of GPs who can be requested to attend to persons in custody as required. Facilities are provided within each Station for the Doctor to administer the appropriate treatment in private.
			It is not the role of the Garda Siochana to in any way regulate or control the clinical role of a doctor who is called to treat a person in custody.
			The prescription of methadone to persons in Garda custody should be seen in this context. In the view of this Department is it a medical intervention similar to any other. Neither the Misuse of Drugs Regulations, 1998, nor the Methadone Treatment Protocol, appear to make exceptions for persons in Garda custody. The treatment for whatever medical condition is encountered in the context of Garda custody is a matter for the medical practitioner.

7. To review the MTP with regard to data collection, collation and analysis

Sub. ID	Source if individual	Organisation	Submission
2		Addiction Services Dublin Mid-Leinster South Western Region	Scope for increasing data analysis. The CTL is a considerable asset in relation to information on drug treatment. However there may be opportunities to increase the statistical analysis of the data that is located in the CTL.
5		Sharing Point	Available and appropriate statistics. Additional data should be gathered and made available to enable better analysis and review of service. To include: the size of waiting lists to receive methadone; details for each service user on the programme by gender, by amount and by length of time; the number of people who wish to access and have accessed support for stabilisation and the numbers who have accessed support for detoxification; the number of people who have been refused support to access detoxification; and any common issues/themes arising among service users that manifest during the review with their GPs.
10		CASP	Data on long term impact of methadone. Also identified within the review of service users was possible research into the long term impact of methadone on individuals prescribed such? The terms of reference of this review however may need to include issues that are not specifically health related. Considering the initial rational for methadone use in terms of harm reduction and reduction in crime etc, factors relating to same may also need to be considered in research process.
17		OMD	CTL development. The CTL should be further developed within the context of the development of the overall Drug Treatment Reporting System, and with a view to insuring that it can provide information on the outputs and overall progress/outcomes being achieved. We would stress the importance of putting in place a unique identifier to facilitate the development of reporting systems, as envisaged under Action 52 of the National Drugs Strategy.
			Additional data. The OMD would like to see the capacity to extract data on new entrants and all clients including drug use histories, waiting times for treatment and outcomes of treatment, progress through services - moving from Level 2 to Level 1 GP care, successful completion of substitute treatment.
18		Northern Area Voluntary Cluster and Dublin North Inner City Drugs Task Force (submissions received separately, merged here due to crossover of themes)	Greater transparency of data. Quarterly publications of all data should be made easily publicly available. Data should include statistics on service user move on and any information relating to rehabilitation and service provision.
			Development of quality individual tracking system. To assist in reviewing progression a system across all clinical treatment services should be established that provides data on: care plan reviews, interagency plans in place, and service user progression. This should include the work that community and voluntary services undertake.
20		Traveller Specific Drugs Initiative, Pavee Point Travellers Centre	Use of an Ethnic Identifier and its introduction to the care planning process. Clinical, community and voluntary treatment and rehabilitation services should record ethnicity during the development of a care plan and review process. Knowing a service users ethnic identity will impact on the development of not only their treatment regime but also their care plan, ultimately playing a role in their level of engagement with services. Training should be provided to these services to ensure that the importance of having an ethnic identifier in care planning documentation is fully understood and that answering this question honestly will not negatively impact their treatment.
			Clear system to review progression through drug treatment pathways. To facilitate the review of service user's progression through drug treatment pathways, a clear system for recording care planning, inter-agency working and blocks to progression needs to be established. If Traveller service users highlight a particular block to their progress, this needs to be recorded and assessed.
27	Dr John Moloney		Additional data. Targets for data collection should include liver morbidity and mortality, rehabilitation outcomes in community based clinics. Online results from the virus reference lab would be very useful for clinicians.
29		HSE Addiction Services Dublin North Central and Dublin North	Additional information. Use of the NDTRS forms for further information of treatment in primary care; identify numbers attending Level 1 and Level 2 GPs from the CTL and that numbers are separate from the drug treatment clinics; outlines numbers on methadone maintenance who also detox off methadone; and the numbers of new clients started on methadone treatment by Level 2 GPs.
			National Standards for the completion of entry and exit forms / voiding from the CTL are required.
			Agreed Standards in relation to treatment programme and urinalysis to feed into collation, collection and analysis of data.
			Use of service user satisfaction surveys. To implement measures that allow service users to change their GP or pharmacy if requested.
30		Soilse - Service Users	Everyone in treatment should be able to access their treatment data and it would be a good way of motivating them

Sub. ID	Source if individual	Organisation	Submission
31		SOILSE - Staff	Services to provide data to NDTRS and CTL. All services should provide data starting with the NDTRS. This should be reported punctually annually. Further data should be provided on a clinical level-numbers in treatment per DED by way of the Central Treatment List-on a quarterly basis to each Addiction Service and Drug Task Force. This will accurately show service uptake per area and allow for appropriate responses
			Data collection methods need to be established to feedback on relevant variables – for example care plans opened and audited, uptake in detox and rehabilitation, progression etc. DAIS was supposed to be this vehicle. This should also include customer satisfaction surveys and should be comprised of both services users and service providers.
			Focus on qualitative research. There should also be a shift to rebalance research and focus on qualitative research, particularly around the experiences of our service users and their structural marginalisation, more than just a feedback from narrow clinical determinants. A medical solution is incongruous to a social problem. Service outcomes should also be based on quality of life and social inclusion indicators – addressing poverty / secure housing or accommodation / family integration / training, educational and employment opportunities / health and lifestyle indicators / community integration / increased esteem or reduction of stigma etc.
			Children of parents on methadone. One of the main themes in drug work is children and the social reproduction of conditions and behaviour. For children of parents on methadone, there needs to be a robust response, family reinforcement and support to minimise risk of systemic addiction. In a wider context children are living in a system where methadone is heavily stigmatised and where children can become contextualised by this – arrested development, isolated and enculturated. The scope and scale of this needs researched. There is an absence of data relating to children living in addiction in Ireland.
			Quantitative outcomes are too narrow and medical based – less using, reduced offending, less infection etc. This focuses on symptoms rather than underlying issues or causes. It means success re: less using, reduced offending and less infection is taken as the ultimate goal. Sources of data limit the discourse. It fails to show how drug users fail to interface with normal life or achieve their reorientation and reintegration which is their goal. Indeed this is a major weakness of the UK Four Tier Alcohol Model which fails to set itself in a social context.
			All data should be unified in a manageable format. We would suggest this review should elaborate on what we need to collect. The aim of data collation and analysis is to determine the effectiveness of outcomes being achieved by services. In turn it should influence the framing of policies and contribute to setting service gaols.
41		FSN	Data on families. Develop a record of the number of patients on the MMT list whose family members are accessing a family support service. This will encourage referrals to family support services and strengthen the support system for those on treatment.
43		Ballyfermot Advance	Data must represent the individual on methadone and include length of time in treatment, detox attempts etc.
			Transparent and regular publishing of data required,
46		Drug Treatment Centre Board	Access to CTL out of 9-5 working hours. In line with treatment expansion, consideration needs to be given to access requirements outside working hours. We recommend consideration to enhancement of online access to the CTL out of hours and to electronic treatment cards.
			Scope of CTL be expanded to include Suboxone and any other future treatments that may become available.
			CTL database enhancements have been carried out over the years, we recommend that this be further reviewed in line with additional data requirements in respect of data collation and enhanced reporting requirements. Current reports should be enhanced to include routine reports on patient pathways, progression and entry/exit data. We also recommend the introduction of client PPS number as unique identifier.
48		Kilbarrack Coast Community Programme	Lack of data hindering review. Time on treatment and progression indicators would be powerful evaluation tools but appear not to be available at present. There is a lack of relevant data; whilst it is possible to ascertain at any given time how many people are being prescribed methadone, it is not possible to find out how long each person has been receiving it. It is not possible to find out how many people who have been prescribed methadone since 1971 are not living drug-free lives, or how many current methadone clients are involved in ongoing illicit opiate misuse.
50		Consultants in Substance Misuse	New technologies. Explore new technologies in relation to electronic completion and transfer of data to and from the CTL. Key performance indicators could be developed in relation to transfer of patients for example the length of time taken for transfer to occur. The DOHC need to make a determination in relation to electronic prescribing. Regular audit of data collection and compliance of practitioners in this respect should occur. Analysis of data already collected would be interesting and important, particularly in the area of retention in treatment. Analysis already exists from the CTL and this could be enhanced but much will depend on the practitioner entering data on a regular and timely basis
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Data should be collated and recorded regarding patient treatment pathways from specialist clinics to community based GPs and community pharmacists. The standardised NDRIC referral pathways document which may be adopted nationally to fill this purpose. The exit and entry forms completed by treating GPs/pharmacists should be reviewed with the objective of increasing information and providing a standard report on the patients pathways in treatment.
			Patient satisfaction questionnaires should be collected as a quality assurance tool.

Sub. ID	Source if individual	Organisation	Submission
55		South Western Regional Drugs Task Force	Data should be used to assist service development. Drugs Task Forces are mandated to develop specific plans to address substance use in their specified areas. Anonymous data from the MTP should be forward to either the task forces or the offices of the minister for drugs in order to assist planning and development of services.
			Database on GPs that have received training and participating pharmacies should be made available to drugs task forces in a joined up approach to assist in resource allocation and co-ordination.
56		Citywide	Data expansion. Data collection systems should be expanded to include the work that community and voluntary services undertake, to ensure that data is captured on care plan reviews, interagency plans, and service user progression.
60		Irish Association of Alcohol and Addiction Counsellors	To assist with reviewing progression a system across all clinical treatment should be established that provides data, particularly on the number of people: on waiting lists to receive methadone; in receipt of methadone by gender, by amount and by length of time; who wish to and have accessed support for stabilisation and/or detox; who have been refused support to access detoxification.
61		North Dublin City and County Regional Drugs Task Force	Data collection would be more beneficial if collated centrally and is accessible,
			Ethical issues with client details and client confidentiality to be considered.
66		HSE Social Inclusion	Data should reflect service outputs. We will develop a model of data collection that will reflect outputs as regards existing services rather than merely numbers in treatment and those waiting for treatment.

8. Miscellaneous/Outside Terms of Reference

Sub. ID	Source if individual	Organisation	Submission
1	Dr Garrett McGovern		Buprenorphine. This valuable drug is not widely available in this country and the Department of Health has now declared that it will not be funding use of the drug any longer. This drug is widely used in the US, Australia, UK and many other countries and should be available for the treatment of opioid dependence in Ireland.
			Drug users in prison should receive the same quality of treatment as those patients in the community. There are prisons (e.g. Castlerea) that do not provide opioid agonist treatment at all. This is unacceptable and needs to be urgently addressed.
2		Addiction Services Dublin Mid-Leinster South Western Region	Absence of pharmacy in the terms of reference. Pharmacy plays a critical role in the methadone protocol and should be a feature of any review of the protocol. In much the same way as the general practitioner role has been examined the role of pharmacy should also be examined given their critical function in the operation of the protocol. The role of the Liaison Pharmacist should also be a feature of the review.
4		Ballyfermot STAR	Street Methadone. We are made aware that some individuals who are being prescribed methadone from local doctors ingest their methadone in the local chemist and take out the remaining week's supply. On some occasions this methadone is sold on the streets of Ballyfermot. The methadone is mixed with all sorts of other substances and is not a reliable or safe resource for those waiting for treatment.
7		CARP Killinarden	Protocol should not be entirely in the hands of medical people. All future reviews of the protocol should have an independent chair and representatives from community and voluntary sectors, service users/patients' rights groups, Garda and business community. The good of the individual should guide the protocol and it should take into account the needs of the family and community of the person on the protocol.
			Patient complaints. There needs to be an independent ombudsman to deal with patients' complaints
13	Dr Hugh Gallagher		Pharmacists should be empowered to resist dispensing scripts that are contrary to acceptable practice and to report such issues of significant concern and if persistent.
			Methadone Protocol Implementation Committee. There is a need for strict rules of attendance at MPIC meetings and a review of the purpose and functioning of that committee.
15		Southern Region Drugs Task Force	Definition of maintenance implies long-term care, suggest maintenance be replaced with stabilisation
17		OMD	Service use engagement. Review of measures to encourage heroin users to engage with services
			Other pharmacological therapies. Consideration of the appropriateness of most clients in Ireland being limited to methadone as an opiate substitute, rather than having a choice available to their treatment providers
			Young people. Appropriateness of opiate substitution treatment for young people with a short history of opiate use
27	Dr John Moloney		Dialogue with clinicians. Proposed developments to methadone treatment protocol should be circulated in draft form initially with opportunity for feedback.
30		Soilse - Service Users	Methadone in Prisons. If you're on maintenance before your sentence you will get a maintenance when you go in. Medical units can only house 9 people (5,000 prisoners), it can sometimes take up to 6 months to access a bed in there. More places are needed. Groups and meetings would enhance a recovery culture. There is counselling services available, but not everyone can avail.
33	Dr Colm Quinn		Details of prescribing. Leaving aside the "handwriting issue" which has exercised many of my colleagues the "7 Days Supply" seems to be impossible to get around, resulting often in 2-3 scripts having to be written for a patient going on holiday. I think thought should be given to Emailing Scripts directly to Community Pharmacies.
37	Dr Declan O'Brien & Dr Don Coffey		Other pharmacological therapies. We are disappointed that other treatment options such as buprenorphine and lofexedine have not been licensed to be more widely available. Buprenorphine has advantages for some clients and its safety we feel has been documented internationally at this time.
41		FSN	Polydrug use. Family members are concerned about the high level of polydrug use and the impact that this has on the family. Some family members are of the opinion that this seemed to escalate with the change over from physeptone to methadone.
			Review of benzodiazepie prescribing. They are too freely available in some cases and contribute heavily to polydrug use.

Sub. ID	Source if individual	Organisation	Submission
49	Dr Desmond Crowley		Last review failed to review the hand writing exemption. 1000s of doctor hours are lost each year because of failure to address this issue. It would reduce errors, improve compliance with regulations and improve documentation and record management. This is a matter of utmost importance to the generation of cost savings and efficiency within the service while minimizing risk issues as a matter of fact.
			CTL anomalies. The Central treatment list (CTL) works effectively, but they are still some outstanding anomalies that need to be addressed. When prisoners are incarcerated their treatment card remains active for a month even though they are prescribed and dispensed methadone at an alternative location. They are on two different locations on the CTL for this period.
			Regulation anomalies. A patient who is released on a phased bases from the IPS gets dispensed two days weekly in a community clinic and five days weekly in the prison, again this is not covered by the regulations. Interestingly this scenario is likely to increase in frequency in the future with increasing numbers of patients being prescribed methadone in the IPS estate.
			Timely to review the hospital exemption. Many patients are now initiated in hospital, often with poor communication with community addiction services. This has on occasion lead to problems with seamless continuity of care with its inherent risks.
50		Consultants in Substance Misuse	Other pharmacological therapies. The MTP should be amended to allow for the use of other opioid substitutes in Opioid Substitution Treatment
51		Pharmacy Co-ordinators, HSE Dublin Mid-Leinster and Dublin North Central; and Primary Care Pharmacist, HSE North East	Absence of pharmacy from terms of reference for this review. The provision of a daily dispensing service by community pharmacies must be regarded as an integral component of the MTP. The success achieved by the MTP since 1998 and the development of service to the present point has been dependent on pharmacy services.
53	Marie Wright, Senior Pharmacist		Review of current methadone prescription. Currently prescription assumes that patients are on once daily treatment however most palliative care patients are treatment with methadone either twice or three times daily. The prescription asked for a total daily dose and there is no where to state a frequency of more than once a day. This leads to poor communication with out GPs who take over prescription after initiation by our consultants and also poor communication with the community pharmacists as they have no information from the prescription about the frequency of the treatment.
56		Citywide	The MTP should be renamed the Opioid Replacement Treatment Protocol with the range of medication on offer extended to include other drug therapies like Suboxone and Subutex

Appendix 3

Methadone Regulations

The Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998 came into operation in July 1998.

These regulations state that: -

When a registered medical practitioner intends to prescribe a specified controlled drug to a person for the first time a prescription should not be issued until the medical practitioner notifies the Eastern Health Board of the name, address and date of birth of that person. The Eastern Health Board shall maintain a record (the Central Treatment List) containing this information, which may be maintained in electronic form. The Eastern Health Board may amend an entry in or delete an entry from this list. The Eastern Health Board shall inform the medical practitioner if the person is previously on the list.

A health board shall issue a drug treatment card for a person participating in the scheme after they have been notified to the Eastern Health Board (EHB). This card is valid for a maximum of one year from the date of issue. A medical practitioner shall only issue prescriptions for the specified controlled drug on the special forms supplied and only to a client with a valid treatment card.

A pharmacist can only supply the specified controlled drug on a specific prescription to a person who has a valid treatment card. The pharmacist must forward to the Department of Health the original prescription.

The Minister shall maintain a record of all prescriptions received by him, which may be kept in electronic form, and the Minister may amend or delete an entry. Each prescription should be kept for two years.

Exemptions: -

Hospitals: - The regulations shall not apply to prescriptions issued in respect of a specified controlled drug where the prescription has been issued in a hospital for administration or supply in the hospital to a person who attends the hospital for treatment of opiate dependence or who is an in-patient who is opiate dependent.

Medical Consultants: - the regulations do not apply to a prescription issued for the treatment of a person other than in connection with opiate dependence provided that the medical consultant's name and address is on the prescription and that the official prescription form is used.

It should be noted that best practice is that opiate dependent patients should not be treated in a hospital setting without appropriate contact with the addiction services.

Appendix 4

Useful methadone prescribing and urinalysis guidelines and reports from other countries:

Global;

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence
World Health Organization (2009). Geneva

Europe

EMCDDA Best Practice Portal with National Clinical Guidelines for all member states
http://www.emcdda.europa.eu/best-practice/standards/treatment (accessed November 10th 2010)

Australia:

Review of Methadone Treatment in Australia
Final Report: October 1995
Commonwealth Department of Human Services and Health

Methadone Maintenance Treatment: Clinical Practice Guidelines
New South Wales Health Department 1999
ISBN: 0 7347 3002 0

Canada:

Specific Guidelines for Methadone Maintenance Treatment
Correctional Service of Canada, November 2003

UK:

Guidance for the use of methadone for the treatment of opioid dependence in primary care
Royal College of General Practitioners
Available at www.smmgp.org.uk

Drug Misuse and Dependence: UK Guidelines on Clinical Management
Produced by the Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.
Copies are available in electronic form at www.dh.gov.uk/publications and from the National Treatment Agency for Substance Misuse at www.nta.nhs.uk/publications

US:

Comparing Drug Testing and Self-Report of Drug Use among Youths and Young Adults in the General Population
Lana D. Harrison, Steven S. Martin, Tihomir Enev and Deborah Harrington
Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
This publication can be accessed electronically through: http://www.samhsa.gov and http://www.oas.samhsa.gov

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