Comptroller and Auditor General
Special Report

Department of Community, Rural and Gaeltacht Affairs

Drug Addiction Treatment and Rehabilitation

March 2009

This report was prepared on the basis of information, documentation and explanations obtained from the public bodies referred to in the report. The draft report was sent to the Health Service Executive, the Courts Service, FÁS and the departments of Community, Rural and Gaeltacht Affairs, Justice, Equality and Law Reform and Health and Children. Where appropriate, the comments received were incorporated in the final version of the report.

Report of the Comptroller and Auditor General

Drug Addiction Treatment and Rehabilitation

I have, in accordance with the provisions of Section 9 of the Comptroller and Auditor General (Amendment) Act, 1993, carried out an examination of the publicly-funded treatment and rehabilitation services provided for persons with drug addictions.

I hereby submit my report on the above examination for presentation to Dáil Éireann pursuant to Section 11 of the said Act.

John Buckley
Comptroller and Auditor General

13 March 2009

Table of Contents

Abbreviations

CTL	Central Treatment List
FÁS	Foras Áiseanna Saothar/Training and Employment Authority
GP	General Practitioner
HSE	Health Services Executive
NACD	National Advisory Committee on Drugs
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System

Summary of Findings

Summary of Findings

Drug addiction treatment and rehabilitation services are provided through a wide range of publicly-funded agencies. These include the Health Service Executive (HSE), community-based GPs and pharmacies under contract to the HSE, a range of community and voluntary groups, parts of the criminal justice system and FÁS. In addition, 24 area-based drugs task forces are involved in planning and coordination of drug-related services in their respective areas.

Strategic objectives for drug addiction treatment and rehabilitation service delivery were set in the National Drugs Strategy 2001-2008. These were

- to encourage and enable those dependent on drugs to avail of treatment, with the aim of reducing drug dependency and improving overall health and social well-being and, ultimately, leading a drug-free lifestyle
- to minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

A number of government departments have functions in this area. The Department of Community, Rural and Gaeltacht Affairs has overall responsibility for coordinating the implementation of the National Drugs Strategy, and has established a number of coordination structures. The Department of Health and Children is responsible for the national policy on drug misuse treatment generally. The Department of Justice, Equality and Law Reform has responsibility for policy in dealing with drug treatment provision in the prison and probation systems.

This examination looked at all the main publicly-funded treatment and rehabilitation services provided for persons with addiction to illegal drugs (mainly cannabis, cocaine, ecstasy and heroin). In particular, it looked at the extent to which the demand for treatment and rehabilitation services is met, and the timeliness of access to treatment. It also looked at the extent to which the effectiveness of treatment and rehabilitation services are evaluated, and the effectiveness of the arrangements for coordination of treatment and rehabilitation at an individual case level, and nationally.

Delivery of Treatment

Treatment for Opiate Drug Use

It has been estimated that less than 0.5% of the population use opiates of which heroin is the most commonly used. In the past, its use was concentrated in the greater Dublin area, but there is evidence that the use of heroin has increased in other areas in recent years.

Methadone-based substitution treatment is the main form of treatment for heroin addiction. At end 2007, just over 8,000 people were receiving methadone treatment. Around one third of these are treated under the supervision of community-based GPs.

Needle exchange services are provided in some areas with the aim of reducing the risks associated with the sharing of injecting equipment. While there was some increase in the provision of needle exchange services over the life of the Strategy, gaps in service provision remain.

Detoxification treatment for opiate users and follow-on rehabilitation treatment levels are very low, when compared to the numbers receiving methadone treatment. It is estimated the annual level of detoxification treatment is in the region of 100 courses of treatment, at most — around 1.25% of those receiving methadone treatment.

While long-term methadone maintenance is likely to be the best outcome that can be achieved for a significant proportion of heroin users, it would be desirable that the HSE would set target rates of progression through the various forms of treatment. Service capacity planning could then be based on what is required to meet the progression targets.

Treatment for Non-Opiate Drug Use

The prevalence of cannabis and cocaine use among the general population is increasing. The habitual use of a number of drugs at the same time is also on the increase. Despite this, there does not appear to have been a commensurate increase in the number of cases treated for problem use of non opiate drugs over the life of the National Drugs Strategy.

Changes in the pattern of drug misuse creates a challenge for service providers to reconfigure a system geared predominantly to dealing with one drug type in a defined area (e.g. heroin addiction in the greater Dublin area), to one that is capable of dealing with different kinds of addiction in different areas and increasingly, with clients with multiple addictions. The current pattern of drug use suggest that there are, in effect, two separate contexts in which drug treatment has to be provided

- a largely opiate-based addiction problem, concentrated in certain marginalised and poor sectors of society, and in certain geographic areas
- problem use of non-opiate drugs, spread more widely across social groups and geographic areas, and where many of those being treated may have access to more social supports and economic resources.

Although there is a higher prevalence of misuse of all kinds of non-opiate drugs in the greater Dublin area than in the rest of the country, the rate at which users of non-opiate drugs in Dublin enter treatment appears to be significantly lower than for the population elsewhere. There is a risk that this pattern derives from the available facilities and the priorities in the two areas rather than the objective need of the populations served.

While there may be overlaps between the two populations of drug users, the future management of service delivery appears to demand differentiation in targets set, performance measures used and performance reporting.

Demand for Treatment

Information about the level of demand for treatment for problem drug use is very important for service planning purposes, but is incomplete.

A database on treated drug (and alcohol) use in Ireland is compiled and managed by the Health Research Board (HRB). This database, the National Drug Treatment Reporting System (NDTRS) relies on treatment service providers to collect details on each individual who presents for treatment. The information is transmitted to the HRB, but without the personal identification details (e.g. name or address) of the individuals receiving treatment. The result is that while the number of courses of treatment delivered can be identified, it is not possible to track the progression of an individual from one service provider to another.

The NDTRS has the potential to generate better estimates of demand for treatment, but greater compliance by service providers with the NDTRS data input rules would be required if this is to be achieved.

In the case of methadone treatment, delivery is recorded on a Central Treatment List, which is a statutory register of all patients receiving methadone as an opiate substitute in Ireland.

Ways of recording treatments sought and provided on an individual basis and in a manner that ensures security of the information need to be established. This should be tackled by the HRB in liaison with service providers and with the Data Protection Commissioner. In this context, consideration could be given to upgrading the current NDTRS case recording and reporting system, perhaps moving to an internet-based system.

Access to Treatment

This examination found that the NDTRS data may underestimate the extent of waiting for assessment. The practice in some areas is that recording of information for NDTRS purposes starts only at the time of assessment, rather than at the time of initial presentation or referral. Some service providers also operate informal waiting lists only calling those on the list when an assessment appointment becomes available. In addition, where drug users are aware of long waiting times for access to local services, they may be deterred from presenting for assessment.

The HRB needs to put more emphasis on ensuring that all service providers record information completely and accurately so that the true extent of waiting for treatment may be gauged.

Subject to these reservations, analysis of NDTRS data indicate an estimated 82% of those beginning methadone treatment in 2007 commenced treatment within the one month target following assessment. In almost all non-opiate cases, treatment was provided within the target one month from date of assessment.

While a high proportion of individuals commenced treatment within the one-month target, approximately 460 people were recorded as waiting for methadone treatment in April 2008. The average waiting times for those on the lists in some areas were over a year.

A target of carrying out an assessment within three days of presentation (or referral) for treatment has been set. Of the opiate cases recorded by the NDTRS for 2007, an estimated 61% were reported to have been assessed within three days of initial presentation. Almost one in eight of those assessed were reported to have waited more than a month for their assessment. For persons presenting for assessment for cocaine use problems in 2007, around 56% were recorded as having been assessed within the three-day target. Of those presenting for assessment for cannabis or stimulant use problems, less than 40% were assessed within the target time.

Effectiveness of Treatment

Evaluation of treatment effectiveness is complex. Nonetheless, some sound and informative work has been done in relation to treatment of opiate addiction in Ireland.

A large-scale longitudinal study was carried out to identify the outcomes achieved for a sample of over 400 persons receiving treatment for opiate addiction or availing of needle exchange in 2003/2004 (referred to as the ROSIE study). The study team carried out follow-up interviews after a year and again after three years. The rate of response for both rounds of the follow-up interviews was high, and was significantly better than response rates for similar studies carried out elsewhere.

The study found that the level of retention in treatment was high with 69% of respondents in treatment at the three-year follow-up (some may have dropped out and re-entered). Of those still in treatment, 86% were on methadone maintenance treatment. The report also found that there had been reductions among those interviewed in the reported rates of illicit use of drugs and of involvement in crime, and increased rates of employment and independent living. No significant improvement in health status was noted.

It could be useful to carry out a further follow-up on the respondents to the ROSIE study in order to help identify the long-term outcomes for those that receive treatment for opiate addictions. Consideration

should also to given to commencement of a similar study of a new cohort of individuals presenting for treatment for opiate addiction. This would help identify the extent to which current treatment and rehabilitation services are effective for opiate misusers presenting for treatment now.

The effectiveness of treatment for non-opiate addictions also needs to be formally evaluated in order to inform the design of treatment programmes.

Significant resources have been invested in pilot schemes with the aim of identifying the best approaches to provision of treatment for problem cocaine use. At this point, the evidence from these pilot projects should be distilled in order to identify effective treatment approaches. The most effective approaches could then be taken into account in designing national treatment capacity and in setting target outcomes for publicly-funded programmes to tackle problem cocaine use.

Drug Treatment and Rehabilitation in the Justice System

Many users of illegal drugs, and in particular heroin users, end up in contact with the criminal justice system.

Drug Treatment in Prisons

Overall, information about the incidence of drug use among prisoners needs to be improved in order to have a better picture of the progression of those treated in prison and their treatment outcomes.

In regard to treatment provision, methadone treatment is provided in eight prisons that together accommodate 74% of the prison population. Annually, between 12% and 15% of those committed to prison are admitted to methadone maintenance treatment. At the end of 2007, around 500 prisoners were on methadone maintenance.

Where methadone maintenance treatment is not provided to a prisoner, a short methadone-based detoxification may be provided instead. The Prison Service does not routinely compile or report data on how many prisoners undergo this kind of treatment.

A rehabilitation programme is provided at Mountjoy prison. There is capacity for around 70 prisoners a year on the programme. Participation in the rehabilitation programme, and the rate of completion have varied. This may reflect the level of availability of methadone maintenance treatment.

Drug Treatment as Part of Community-Based Sanctions

In cases where offenders have drug use problems, undergoing treatment or rehabilitation may be a condition of community-based sanctions. The Probation Service is the agency responsible for supervising offenders sentenced to such sanctions. Most of the treatment availed of by offenders under supervision is provided in the normal community-based services. Offenders are not given priority for access to treatment.

The Probation Service is taking steps to improve and enhance its case management data, but there is scope to manage the referral process more effectively. It should, in particular, monitor the length of time that offenders wait for assessment or treatment and the number of offenders that are unable to access required treatment places. The Service should also monitor the outcomes of court-ordered treatment for the cases it supervises.

The Dublin Drug Treatment Court

A Drug Treatment Court (DTC) was established in Dublin in 2001. A drug addict who has been convicted of a non violent crime may volunteer to be referred to the DTC for inclusion in a supervised

programme in return for a reduction or striking out of charges. Admission to the DTC programme depends on an offender being both eligible and suitable. An individual plan is developed for each participant found suitable for admission to the programme.

When the DTC was established, it was envisaged that it would handle around 100 cases during the initial 12-months of operation. In practice, an average of 22 offenders a year were admitted to the programme from January 2001 to July 2008 i.e. just over one fifth of the initial annual target.

Excluding those still on the programme around 83% of those admitted had their participation terminated by the Court and were referred back to the original court for sentencing. Just 17% of programme participants (22 individuals) completed the full programme to the satisfaction of the Court.

The DTC currently serves the Dublin 1 and 7 areas only. The Courts Service has proposed its expansion, but the necessary commitments from other agencies involved have not yet been made to give effect to this expansion.

The effectiveness of the DTC needs to be evaluated, now that a significant period of operation has elapsed. The evaluation should compare the cost and effectiveness of the Court with the cost and effectiveness of orders made by other courts that include treatment of those sentenced to community-based orders. This should help identify the most appropriate way to develop the service in the future.

Social Support and Reintegration

Drug use problems are often associated with significant difficulties in the personal lives of the users and/or of their families. These may include breakdown in family life and personal relationships, money problems, poor educational achievement, and loss of employment or of the home. Where these difficulties arise, other forms of social support and reintegration interventions may be required if treatment of drug addiction is to be effective in the long-term.

In the future development of care planning and key working systems in the context of treatment and rehabilitation for drug use, consideration should be given to the wider social supports required by the individuals concerned e.g. accommodation, education and training.

Many of those receiving treatment for problem drug use are early school leavers, with low educational attainment and a history of unemployment. FÁS has provided for up to 1,000 Community Employment places to be made available for drug users in rehabilitation but these have not been utilised in full. Further special programmes in the areas of basic education and training — such as the pre-Community Employment stabilisation initiative — are now envisaged, aimed at ensuring that those with the greatest skill and competence deficiencies have an opportunity to progress to other forms of training and education.

FÁS should regularly review the outcomes of special education and training programmes for those receiving treatment for drug use problems. The effectiveness of special Community Employment schemes for people in drug rehabilitation should also be evaluated from time to time.

Waiting times for accessing required social support services should be formally monitored and reported on.

Care Planning and Management

The National Drugs Strategy envisaged that treatment services would be based on a continuum of care model and a key worker approach. The aim of this approach is to provide coordination of services and smooth transition between the different phases of treatment. The relevant key worker was envisaged as

being a central person for primary care providers (e.g. GPs and pharmacists) to contact in connection with an individual drug user in their care.

Achievement of a continuum of care in the delivery of treatment and rehabilitation depends on effective care planning and management systems, including arrangements for effective coordination between agencies. A planned national framework for care planning and management has not been developed by the HSE. Nonetheless, examples of good practice have developed in some areas.

As a result, in areas where coordination arrangements remain under-developed, there is scope to learn from good planning and management structures in areas with more advanced systems. Good practice opportunities identified during visits to local areas and service providers in other jurisdictions in the course of this examination include

- assignment of a care manager for each individual seeking treatment, to plan and oversee delivery of the full range of services required, including treatment, support and rehabilitation
- identification of a key worker in each of the service providers to ensure that the planned services are delivered for the individual
- an individual care plan, setting out the ultimate treatment objective and the planned progression for the individual, and identifying the services to be provided and the sequence and timing of their provision
- scheduled review of case progress and amendment of the plan in response to the individual's evolving needs
- timely availability of the planned treatments.

Coordinating and Monitoring the Strategy

Concerns have been expressed about how well the co-ordination system works, not least in the 2005 report of the mid-term review of the National Drugs Strategy. The proposal in the 2007 Report of the Working Group on Drugs Rehabilitation to establish a further co-ordination structure for rehabilitation, and a separate pillar to focus more attention on the needs of service providers in that area, suggest that the existing coordination was not fully effective.

Coordination mechanisms need to be improved in order to ensure that consultation and decision making structures are streamlined and effective.

A significant amount of treatment and rehabilitation effort is delivered through a variety of local projects, overseen and monitored by drugs task forces, which are comprised of representatives of relevant state agencies and of local communities. This structure is designed to ensure that projects continue to fit in with local needs and priorities for services. It is important in order to maintain a focus on delivery that all local projects whether operating on an interim or mainstreamed basis, be governed by service level agreements that specify the services to be provided and the standards to be met.

The main focus in the monitoring of the National Drugs Strategy has been on progress in delivery of planned actions by the various responsible agencies. While a focus on implementing actions is necessary, it needs to be supplemented with programme achievement information so that the effect of those actions can be gauged.

There is also a need for greater transparency on the cost of treatment and rehabilitation services. Performance in terms of both targets achievement, and budgetary outcome should be reported regularly.

Drug Addiction Treatment and Rehabilitation

1 Introduction

1.1 Addiction to illicit drugs frequently results in significant harm to the drug users, to their families and communities, and to society as a whole. Treatment is difficult because of the nature of addiction and because of the many adverse ways in which habitual drug use may affect an individual's life.

1.2 The main illicit drugs used in Ireland are generally categorised into two main groups — opiates, such as heroin and non-prescribed methadone; and non-opiates, including cannabis, cocaine and ecstasy. The effects of the different drugs on the user may be quite different. There may also be significant variations in the type of user. A summary of the effects and use patterns of the most frequently used illicit drugs is presented in Appendix A.

1.3 Depending on the type of drugs used and the stage of the addiction, persons seeking help may need to access a wide range of treatment services (e.g. needle exchange, methadone maintenance, detoxification, primary care, counselling etc.) and other supports (e.g. income and housing support, childcare, training and education). Aligning services and supports to specific need is key to the achievement of successful outcomes.

National Drugs Strategy 2001-2008

1.4 Drug addiction treatment and rehabilitation services are delivered in the context of the National Drugs Strategy 2001-2008 (See Figure 1.1). The Strategy set two broad objectives for treatment and rehabilitation

- to encourage and enable those dependent on drugs to avail of treatment, with the aim of reducing drug dependency and improving overall health and social well-being and, ultimately, leading a drug-free lifestyle
- to minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

Delivery of Services

1.5 Treatment for drug addiction and the associated rehabilitation services are provided by a wide range of publicly-funded agencies. These include

- ***Health Service Executive (HSE)*** – the primary responsibility for the provision of treatment services for drug misusers rests with the HSE. It provides services
  - through addiction services in community settings
  - through hospitals and out-patient clinics
  - through community based GPs and pharmacies, under contract
  - by funding voluntary and community organisations to provide services similar to or ancillary to the directly-managed HSE services.
- ***Voluntary and Community Groups*** — Many voluntary and community groups receive state funding through the HSE to deliver treatment, including direct provision of treatment services, rehabilitative care, advocacy and the provision of information and support.
- ***Irish Prison Service*** — The Prison Service provides addiction treatment for some prisoners during detention.

Figure 1.1 The National Drugs Strategy 2001-2008

The National Drugs Strategy 2001–2008 was published in April 2001. Its stated overall objective is "… to significantly reduce the harm caused to individuals and society by the misuse of drugs". The Strategy sought to bring together the many agencies involved in combating drug misuse and its effects, so that their efforts would be co-ordinated within an overall policy framework based on four pillars

- the **supply reduction pillar** – aimed at interrupting and reducing the supply of illicit drugs to the Irish market
- the **prevention pillar** – aimed at reducing the demand for illicit drugs by educating potential or actual misusers about the effects of drug misuse
- the **treatment pillar** – aimed at helping habitual misusers to deal with their addictions and the associated problems, with the ultimate aim of leading a drug-free lifestyle
- the **research pillar –** designed to inform and evaluate the performance and effectiveness of activities and initiatives.

In order to achieve these objectives, the Strategy proposed a set of actions to be taken by a range of agencies involved in drug-related activities. A plan published in 2004 outlined how these actions were being delivered and the timeframe for delivery.

The planned actions in relation to the delivery of treatment and rehabilitation services are listed in Appendix B.

A mid-term review of the Strategy (published in 2005) reported in general terms on the progress made in implementing the actions and also identified a number of areas that needed to be prioritised in the remaining period up to 2008. Overall, the review endorsed the Strategy.

One of the recommendations of the mid-term review was the division of the original treatment pillar into separate but co-ordinated treatment and rehabilitation pillars. As part of this recommendation, a working group was set up to develop a strategy for the provision of integrated drugs rehabilitation services and to report on the appropriate policy and actions to be implemented. The Report of the Working Group on Drugs Rehabilitation was published in May 2007.

- ***Probation Service*** — The Probation Service provides assistance in relation to drug use and addiction issues to individuals in places of detention and to individuals subject to Court-ordered supervision in the community.
- ***FÁS —*** The Community Employment Scheme run by FÁS includes special Community Employment projects for drug misusers.

1.6 There is no overall programme budget for drug addiction treatment and rehabilitation services. However, the aggregate expenditure on such services by the agencies listed above is considerable. Expenditure in 2007 is estimated to have been at least €140 million.

Service Co-ordination

1.7 The National Drugs Strategy envisaged that delivery of treatment and other services would be based on a continuum of care model. This means that the services required by individuals are provided in a co-ordinated way by the relevant agencies, in the appropriate sequence and at the right time, so as to maximise the likelihood of a successful outcome, and to minimise the risk of those being treated for addiction dropping out and resuming their previous pattern of drug use.

1.8 Responsibility for policy, planning, co-ordination and oversight of delivery of treatment and rehabilitation services is shared between a number of agencies. The Department of Community, Rural and Gaeltacht Affairs (DCRGA) has overall responsibility for co-ordinating the implementation of the National Drugs Strategy, across all the pillars. The Department of Health and Children is responsible for the national policy on drug misuse treatment generally, with the Department of Justice, Equality and Law Reform having responsibility for policy in dealing with drug treatment provision in the prison and probation systems.

1.9 Co-ordination and oversight of treatment and rehabilitation services (and of drugs strategy implementation in general) is effected through two cross-departmental committees, operating under the aegis of the Department of Community, Rural and Gaeltacht Affairs.

- The ***Inter-Departmental Group*** on the National Drugs Strategy comprises representatives of relevant Government departments and agencies at a senior level. Its remit is to oversee progress on the implementation of the Strategy and to review Government policy on issues which may arise. The Inter-Departmental Group makes recommendations to the Cabinet Committee on Social Inclusion.[1]
- The ***National Drugs Strategy Team*** (NDST) consists of representatives of the departments and agencies involved in the National Drugs Strategy. It also includes representatives of the community and voluntary sectors. The primary task of the team is to ensure effective co-ordination between officials in Government departments, State agencies and the voluntary and community sectors in delivering local and regional task force plans.

1.10 In addition to the national-level co-ordination structures, fourteen ***local drugs task forces*** and ten ***regional drugs task forces*** are involved in planning and co-ordination of drug-related services in the areas they serve. Their focus includes preventative activities (such as drug awareness campaigns) and services for drug misusers and their families. They are also involved in overseeing local projects that address specific local needs.

Research into Drug Use

1.11 Two main agencies are funded to compile data and to conduct research into drug misuse in Ireland, aimed at providing good quality information for policy development and service planning.

- The ***Alcohol and Drug Research Unit*** of the Health Research Board (HRB) was established in 1989. It operates the National Drug Treatment Reporting System (NDTRS), through which it compiles data on drug (and alcohol) treatment. The Unit also manages the National Documentation Centre, which maintains a database of up-to-date information about drug use in Ireland and internationally. Funding for the Unit is provided by the departments of Health and Children, Community, Rural and Gaeltacht Affairs and Justice, Equality and Law Reform.
- The ***National Advisory Committee on Drugs*** (NACD) was established in 2000 to advise the Government in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland based on its interpretation and analysis of information and research available to it. It operates under the aegis of the Department of Community, Rural and Gaeltacht Affairs.

1 The Cabinet Committee on Social Inclusion is chaired by the Taoiseach and comprises the Tániste and relevant Ministers. The Local Development and Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs reports to the Cabinet Committee, through the Minister of State, on the implementation of the National Drugs Strategy.

Objectives and Scope of the Examination

1.12 This examination looked at all the main publicly-funded treatment and rehabilitation services provided for persons with addiction to illegal drugs (mainly cannabis, cocaine, ecstasy and heroin). In particular, it focused on

- the demand for treatment and rehabilitation services
- timeliness of access to required treatment
- the extent to which the effectiveness of treatment and rehabilitation is evaluated
- the effectiveness of the arrangements for co-ordination of treatment and rehabilitation at an individual case level, and nationally.

1.13 The examination focused in the main on service provision in the period 2001 to 2007, and looked at the contribution to drug addiction treatment and rehabilitation by each of the agencies listed at 1.5 above.

1.14 Many individuals who suffer from addiction to illicit drugs may simultaneously have an addiction to a legal drug (such as alcohol or prescription drugs) and some services provide treatment for a range of addictions (illicit drugs, alcohol, gambling, etc). This examination focused on services available to persons whose main problem was addiction to illicit drugs.

Methodology

1.15 The examination was carried out by staff of the Office of the Comptroller and Auditor General.

1.16 The work carried out involved a review of documents held by agencies within the scope of the examination and meetings and correspondence with relevant personnel in each of the agencies. The available statistical data in relation to demand for and supply of drug treatment and rehabilitation services was analysed. Reports on evaluations of treatment and rehabilitation programmes were also examined.

1.17 In order to gain an understanding of the nature and range of services involved in the treatment and rehabilitation of those with a drug misuse problem, the examination team undertook visits to agencies providing services in two of the local drugs task force areas in Dublin (Ballyfermot and Blanchardstown) and two of the regional drugs task force areas (Mid-Western and South Eastern). The areas visited were selected to provide the examination team with information about the range of social and organisational circumstances in which addiction treatment and rehabilitation are provided. Findings from the visits are presented in the report to illustrate the kinds of challenges that arise and the various solutions that have emerged in some areas.

1.18 The examination team also undertook visits to the Netherlands and to Scotland, to review how drug treatment and rehabilitation services are managed in other jurisdictions. Where relevant, comparisons are made with the systems in those jurisdictions.

Structure of the Report

1.19 Chapter 2 looks at how the level of demand for drug addiction treatment and rehabilitation is determined. Chapter 3 examines the extent to which treatment planning and management based on the continuum of care model has been established. Chapter 4 examines the provision of treatment for opiate (mainly heroin) addiction in community and hospital-based settings, while Chapter 5 examines the provision of treatment for non-opiate addictions. Chapter 6 reviews the provision of drug addiction treatment in the criminal justice system. Chapter 7 looks at the provision of rehabilitation and support services. Finally, Chapter 8 looks at the systems in place to ensure integration and co-ordination of treatment and rehabilitation services, and the adequacy of monitoring and reporting of performance.

2 Demand for Addiction Treatment

2.1 In planning the provision of addiction treatment and rehabilitation services, it is useful to be able to identify and distinguish between

- the underlying prevalence of misuse of drugs in society, and any significant changes that are occurring in the pattern of misuse
- the rate at which individuals with an addiction problem present for treatment i.e. the demand for treatment
- the level of provision of treatment i.e. the supply of treatment.

2.2 This chapter examines the systems in place to measure and report on drug use and on the provision of drug addiction treatment and rehabilitation services, in order to assess how well the demand for treatment is identified.

Prevalence of Drug Misuse

2.3 There are three widely-used indicators of the prevalence of drug use in a population.

- **Lifetime prevalence** refers to the proportion of the population that report ever having used the named drug.
- **Last year prevalence** refers to the proportion of the population that report having used the named drug in the preceding 12 months. Last year prevalence is often treated as a measure of recent use.
- **Last month prevalence** refers to the proportion of the population that report having used the named drug in the preceding month. Last month prevalence is often treated as a measure of current use of a substance.

It is recognised that a proportion of those reporting drug use may be occasional or one-off users. Consequently, 'last year' or 'last month' use does not necessarily imply regular use.

2.4 Periodic population-wide surveys are undertaken to establish the extent of prevalence of use of illegal drugs. A survey of drug use across the population aged 15 to 64 in Ireland in 2006/2007 found that

- around 24% of that cohort reported using some form of illicit drug at one time in their lives
- around 7% reported having used an illicit drug in the preceding year
- around 3% reported having used an illicit drug in the preceding month.

Individuals reporting drug use under this measure may have used just one form of drug, or may have used several types of drugs.

Prevalence of Opiates

2.5 Population surveys produce less reliable estimates of drug use where prevalence in the population is low e.g. with heroin use, which is concentrated in a marginalised segment of the population. Other forms of analysis have been developed to arrive at estimates of the numbers of problematic opiate users.

2.6 A study of the prevalence of opiate use in Ireland in 2001 concluded that there were an estimated 14,500 users of opiates (mainly heroin) in the age group 15-64 years — around 0.5% of that age cohort[2]. Most of the opiate users (86%) were living in Dublin.

2.7 The Department of Community, Rural and Gaeltacht Affairs has stated that a further study of opiate prevalence is being undertaken but the results are not yet available. Based on other data, the Department is of the view that the use of opiates has stabilised in the Dublin area, but that opiate use outside of Dublin has risen.

Prevalence of Non-Opiate Drugs

2.8 Figure 2.1 shows the rates of use of non-opiate drugs by individuals in the age cohort 15 to 64 years, based on a population-wide survey undertaken in 2006/2007. The key features of the survey findings were

- The illicit drug used most in Ireland is cannabis. In 2006/2007, almost 22% of the population aged between 15 and 64 reported having used the drug at some time in their lives and 2.6% reported current use.
- Only 0.5% of the population aged between 15-64 reported being current users of cocaine. However, 1.7% reported having used it in the last year and over 5% reported having used it in their lifetime.
- The prevalence of current and recent use of ecstasy is slightly lower than that of cocaine.

2.9 The proportion of the population in Ireland aged 15-64 who reported using cannabis and ecstasy in the previous year is around the average for EU countries. The proportion who reported using cocaine (including crack) places Ireland among the high prevalence countries, such as the UK, Spain and Italy (see Appendix C).

Figure 2.1 Prevalence of use of illegal drugs among 15 to 64 year olds in Ireland in 2006/2007

	Prevalence of drug use in		
	last month %	last year %	lifetime %
Cannabis	2.6	6.3	21.9
Cocaine (crack and powder)	0.5	1.7	5.3
Ecstasy	0.3	1.2	5.4

Source: Drug Use in Ireland and Northern Ireland: Bulletin 1 – First Results from the 2006/2007 Drug Prevalence Survey, NACD and Drug and Alcohol Information and Research Unit (Northern Ireland), January 2008.

2 ***Prevalence of Opiate Use in Ireland 2000-2001, A 3-Source Capture Recapture Study***, NACD, July 2003.

2.10 Applying the estimates of recent use for 2006/2007 to the 2006 population of 15 to 64 year olds implies that around 210,000[3] people used one or more kinds of illegal drug during that year. Of these,

- around 183,000 reported using cannabis
- around 49,000 reported using cocaine
- around 35,000 reported using ecstasy.

Recording Addiction Treatment

2.11 There are two primary sources of information about the supply of drug addiction treatment in Ireland. These are the Central Treatment List, maintained by the Drug Treatment Centre Board on behalf of the HSE, and the National Drug Treatment Reporting System, co-ordinated by staff at the Alcohol and Drug Research Unit of the Health Research Board (HRB) on behalf of the Department of Health and Children.

Central Treatment List

2.12 The Central Treatment List is a statutory register of all patients receiving methadone as an opiate substitute in Ireland. A clinic or GP prescribing methadone is required by law to register each client started on a methadone treatment programme. Each person registered receives a unique client number, which is intended to serve as a control so that patients can receive methadone from one source only in a given period.

2.13 The Central Treatment List is considered to be complete with respect to the number of clients receiving methadone treatment, but does not count those who have been referred for assessment and/or who are waiting for treatment.

National Drug Treatment Reporting System

2.14 The National Drug Treatment Reporting System (NDTRS) is a database on treated drug and alcohol misuse in Ireland.[4] The system was established in 1990 in the greater Dublin area and was extended in 1995 to cover all areas of the country. The cost to the HRB of operating the NDTRS in 2007 was approximately €420,000.[5]

2.15 The NDTRS is used to provide data about addiction treatment in Ireland to the European Monitoring Centre for Drugs and Drug Addiction. The data is used in compiling EU-wide statistics, and in developing drug policy for the EU.

2.16 Service providers at drug treatment centres throughout Ireland collect data on each individual who attends for treatment. Excluding the name and address of the individual, this data is transmitted to the HRB on a standard form (see copy at Appendix D) or electronically. In 2007, just over 60% of cases reported were submitted electronically and this was expected to increase to 70% in 2008.

3 Based on an estimated 7.2% of the population aged 15 to 64 reporting having used illegal drugs in the preceding year. At the 95% confidence level, the upper value was estimated at 8.3% (240,000 users) and the lower value at 6.1% (180,000 users).

4 The original remit of the NDTRS was to collect data on problem drug use but it was extended in 2004 to include cases where alcohol is recorded as the main (or only) reason for seeking treatment. Data on alcohol cases are not presented in this report.

5 Expenditure by the Alcohol and Drug Research Unit on its other activities is not included in this figure.

2.17 A review of the capacity of the NDTRS to generate reliable estimates of the demand for drug addiction treatment and the timeliness of treatment delivery found that

- Some service providers do not make NDTRS returns. Service level/funding agreements between statutory agencies and community and voluntary groups reviewed did not specifically require the groups to make returns. The Irish Prison Service do not currently make returns, but the HRB is negotiating with them on the matter.
- Compliance with the NDTRS is voluntary so some service users may opt not to have the form completed. While it is believed that most of those in receipt of treatment consent, there is no record of the number that do not consent to the form being completed.
- In some cases information is not returned to the NDTRS in respect of cases assessed where no treatment is provided. As a result, the numbers presenting for treatment are likely to be undercounted.
- There are varying practices around the recording of the dates of referral and assessment for treatment.[6] In some of the agencies visited, the date of first contact with the service provider – often with an administrative staff member – was not always recorded. In such cases, the NDTRS data was compiled by medical/professional staff when the assessment was starting, and the same date was often recorded for both the initial contact and the assessment. As a result, the length of time individuals are waiting for assessment and treatment may be underestimated.

2.18 One of the actions specified in the National Drugs Strategy required all treatment providers to co-operate in returning information on problem drug use to the HRB.[7] Nevertheless, the HRB was conscious of the risks that the system was not fully capturing the demand for, and supply of, addiction treatment.

2.19 In 2003, the HRB carried out a review of the completeness and accuracy of the records on the NDTRS. It compared its own records for 2001 with those of a sample of cases on the Central Treatment List at the corresponding time. The review found that 61% of the cases on the Central Treatment List were also recorded on the NDTRS. The coverage was higher for cases entering treatment in 2001 (82% coverage) and lower for cases continuing in treatment at 54%. The HRB, HSE and the Central Treatment List have implemented measures to improve the completeness of the NDTRS record.

Case Tracking

2.20 The NDTRS is designed to capture details about each individual treatment intervention. Because the returns are anonymised by removal of the recipient's name and address, movement of individuals between treatment providers cannot be identified. It is also not possible to know the number of individuals treated in any time period.

2.21 The UN Office on Drugs and Crime and the European Monitoring Centre for Drugs and Drug Addiction have jointly published guidance for the measurement of drug treatment demand. They state that "where privacy legislation permits, it is advantageous if treatment data can allow case linking" and suggest that recording an attributor code, consisting of the client's initials, date of birth and gender, would be sufficient.

6 The NDTRS protocol, which is updated and circulated to service providers annually, clearly defines the key data to be recorded.

7 Action number 65, ***National Drugs Strategy 2001-2008***

2.22 Unlike Central Treatment List registration, unique attributor codes are not issued to patients when treatment details are gathered for the NDTRS. The HRB has stated that this is for two reasons

- In 2001 and 2002, the HRB asked service providers to include the initials of clients in the NDTRS returns. Some service providers refused to do so, and there was a significant decrease in returns to the NDTRS.
- The Data Protection Commissioner has indicated that written evidence of informed consent would be required if a unique identifier is included on the form.

2.23 The treatment recording systems observed in the Netherlands and Scotland both use unique identifier codes for service users. This facilitates counting of the number of individual service users and tracking of case progress and outcomes. At the overall system level, this also facilitates evaluation of the relative effectiveness of different treatment interventions.

Conclusions

2.24 There is a reasonable level of information about the prevalence of drug misuse, and the supply of treatment for drug misuse is reasonably well measured. However, there is more limited information on the extent to which the demand for treatment by drug misusers is being met.

In order to respond effectively to problem drug use, policy makers and service deliverers need to build a better picture of

- the extent to which use of illicit drugs develops into problem drug use
- the demand for treatment for problem drug use
- the timeliness of access to treatment.

2.25 Ways of recording treatments sought and provided on an individual basis and in a manner that ensures security of the information need to be established. This should be tackled by the HRB in liaison with service providers and with the Data Protection Commissioner.

2.26 The existing NDTRS has the potential to generate better estimates of demand for treatment, but greater compliance by service providers with the NDTRS protocol would be required if this is to be achieved.

Improving the accuracy and coverage of the NDTRS needs to be addressed so that better estimation of the size of waiting lists can occur, delays in access to treatment can be recognised, progression between forms of treatment tracked, treatment drop-out rates monitored and outcomes and treatment effectiveness evaluated.

2.27 Identification of gaps in service delivery is hampered by a lack of case linking as persons move between service providers. This is largely because service users do not have a unique identifier.

Consideration needs to be given to upgrading the current NDTRS case recording and reporting system, perhaps moving to an internet-based system that allows on-line data input by treatment service providers while restricting access to information held centrally. Such a system could potentially integrate the processes for registering clients on the Central Treatment List with NDTRS reporting. It is acknowledged, however, that this is a matter of policy and would require changes in legislation.

3 Care Planning and Management

3.1 The nature of drug addiction and its effects can require a drug misuser to access multiple treatment and rehabilitation services at different stages. The National Drugs Strategy envisaged that plans for treatment services would be based on a continuum of care model and a key worker approach.[8] The aim of this approach is to provide co-ordination of services and smooth transition between the different phases of treatment. The relevant key worker was also envisaged as being a central person for primary care providers (e.g. GPs and pharmacists) to contact in connection with an individual drug user in their care. The 2007 Report of the Working Group[9] reiterated the commitment to the continuum of care model and to key working.

3.2 A 'Four Tier' framework has been developed for provision of treatment and rehabilitation services for persons under the age of 18, as envisaged under the National Drugs Strategy (action 49). The underlying principle of the framework (outlined in Figure 3.1) is that intervention should be at the lowest level appropriate to the circumstances of the individual presenting for treatment. Effective co-ordination of services is considered to be critical in that context. The 2007 Report of the Working Group indicated that this kind of structured approach is equally valid in the context of treating adults with drug misuse problems.

3.3 This chapter looks at the extent to which systems and procedures for individual care planning and outcome monitoring have been put in place. Access for patients to counselling services, is also reviewed.

Development of Care Planning

3.4 The implementation plan for the National Drugs Strategy[10] indicated that the continuum of care would be developed in a phased way, beginning with pilot schemes in a number of health service regions in 2002/2003. It envisaged formal evaluation of the pilot schemes in 2003/2004, and that thereafter the minimum requirements — including resources — would be agreed, with the aim of achieving a continuum of care for all clients in all regions by late 2006. This target has not been achieved.

National Care Planning Arrangements

3.5 The HSE currently has no central definition of what care planning is, or protocols around how it should be conducted. However, the Working Group on Drugs Rehabilitation recommended that

- ***Protocols*** should be formally developed, at both a national and local level, to facilitate inter-agency working
- ***Service level agreements*** should be developed in line with the protocols, covering responsibility for co-operative inter-agency working and specific commitments regarding the services to be delivered. It also suggested that there might be scope to tie levels of funding available for organisations to the levels and quality of inter-agency working that they undertake.

8 ***National Drugs Strategy 2001-2008***, Action 47.
9 ***Report of Working Group on Drugs Rehabilitation***, Department of Community, Rural and Gaeltacht Affairs, May 2007.
10 ***National Drugs Strategy 2001-2008 Critical Implementation Path***, published in 2004.

Figure 3.1 The Four Tier Model of Adolescent Addiction Treatment

	Specialist skills in adolescent mental health and addiction	Type of adolescent accessing service	Type of intervention for addiction difficulties	Examples of services at this tier	Intensity and duration
Tier 1	No skills	Considering or commencing experiment with drugs or alcohol	■ Basic advice ■ Onward referral	Teacher, GP, Probation Officer, youth worker, A&E, nurse, social worker	■ Low intensity ■ On-going
Tier 2	Either adolescent mental health or addiction	Abusing drugs or alcohol and encountering some problems with same	■ Basic counselling ■ Brief intervention ■ Harm reduction	Juvenile Liaison Officer, Home School Liaison Officer, Youthreach	■ Low intensity ■ Medium term
Tier 3	Both adolescent mental health and addiction	Substantial problems due to drug or alcohol abuse	■ Specialist addiction counselling ■ Family therapy ■ Group addiction therapy ■ Substitution treatment	The specialist adolescent addiction service	■ High intensity ■ Short to medium term ■ (1-6 months)
Tier 4	Both adolescent mental health and addiction and capacity to deliver brief but very intensive treatment	Drugs or alcohol dependence with severe associated problems	■ Specialist addiction counselling ■ Family therapy ■ Group addiction therapy ■ Substitution treatment	Specialist in-patient or day hospital adolescent addiction services	■ Very high intensity ■ Short term ■ (2-6 weeks)

Source: Report of the Working Group on treatment of under 18-year olds presenting to treatment services with serious drug problems, September 2005.

- ***Case management and care planning*** – the HSE should fulfil their lead role in relation to case management by developing templates for individual care plans and nominating care managers to liaise with all relevant agencies to ensure the client receives the appropriate supports and services.
- the establishment of a ***National Drug Rehabilitation Implementation Committee*** (NDRIC), chaired by a senior rehabilitation co-ordinator, to oversee and monitor the implementation of the recommendations in their report
- the appointment of ten ***rehabilitation co-ordinators***.

The Working Group did not outline time targets for the establishment of this model.

3.6 The post of the senior rehabilitation co-ordinator was filled in November 2008, and an initial meeting of the NDRIC was held. In the course of its meetings in January/February 2009 the group agreed to review the recommendations of the May 2007 Drugs Rehabilitation Report and to recommend a practical plan to implement the recommendations.

Local Care Planning Arrangements

3.7 In the absence of a national care planning model, care planning structures vary from area to area. In one of the areas visited during this examination (Blanchardstown), a locally developed continuum of care model has been implemented. Case Study 1 outlines the elements of this initiative.

Case Study 1: The Blanchardstown Equal Inter-Agency Protocol Initiative

EQUAL is a European Union programme, funded through the European Social Fund, which aims to tackle the factors that lead to discrimination and inequality in the labour market. One theme of the programme was to develop inter-agency common protocols for agencies working with current or former drug users.

The Blanchardstown EQUAL Inter-agency Initative commenced in early 2003. The first Phase of the project sought to establish inter-agency protocols and create smoother working relationships to enhance the opportunities for drug users to progress towards employment. It proposed inter-agency working at a service level, i.e. collaboration at practical service provision levels for those directly working with drug users.

The project was led by the HSE Rehabilitation and Integration Service of the Northern Area Health Board and involved a number of statutory and non-statutory agencies including three community drugs teams, the BOND project, Coolmine Therapeutic Community, the Blanchardstown Local Employment Services and the Tolka River Rehabilitation Project.

The project was evaluated by a Steering Group in May 2004 and also underwent independent external evaluation commissioned by EQUAL. Both of the exercises found that the protocols had resulted in significant increases in inter-agency co-operation while also increasing understanding and information flow between the organisations. Between February and April 2004 the total number of inter-agency activities almost doubled, from 22 to 40, with three-way meetings proving to be a significantly used new tool. Inter-agency and lead agency referrals also steadily increased.

The following items were agreed by the agencies involved

- protocol on lead agency working
- guidelines for multi-agency individual care plans
- inter-agency referral form and criteria
- guidelines for multi-agency meetings with a client
- policy on confidentiality and inter-agency release of information form

In October 2004, the group produced a report, “Making Inter-Agency Protocols Work” as a model of good practice for inter-agency working in drug addiction treatment and rehabilitation.

Phase two of the project ran from June 2005 to August 2006. The main focus of this phase was to embed the protocols in the systems and cultures of the agencies involved. Phase two was evaluated in June 2006. This review found that inter-agency working had increased substantially, that staff had an increased knowledge of the services involved, that they were using the protocols and that referral levels were very high. However, it also noted that progress on developing pathways for clients had proved difficult to achieve as basic systems and structures necessary for developing the protocols do not yet exist in some organisations. The evaluation concluded that the initiative should continue.

Phase three of the project is expected to begin in April 2009 and aims to formalise the focus on client progression through the tracking of individual service users via the process from active drug use through stabilisation to rehabilitation to training, education and employment with accompanying (re)integration into the community and labour force.

The fundamental elements of phase three are

- the development of an information/database system for collecting and collating the statistical aspects of the inter-agency work, and
- associated training of frontline workers.

3.8 Agreed protocols on inter-agency co-ordination have been implemented assigning responsibility to individual agencies for the delivery of the required treatment. Procedures have also been developed on identifying the lead agency and on completing care plans for each individual. Similar initiatives have been developed in a number of other areas e.g. the Progressive Routes Initiative managed by the SAOL Community Employment project in the Dublin north inner city area.

3.9 In the three other areas visited during the examination, arrangements were in place for care planning but were not as structured as those in the Blanchardstown area. Some of the treatment and rehabilitation service providers visited did complete care plans but they were generally short-term in nature, outlining the immediate next steps required. There were no procedures in place between the local service providers on how they would link and communicate with each other.

Care Planning and Management in other Jurisdictions

3.10 Arrangements in place for planning and management of care for individuals seeking treatment were examined during visits to treatment service providers in Scotland and the Netherlands. Case study 2 outlines how such a system works in the Glasgow Partnership.

Case Study 2: Care Planning and Management in Glasgow Addictions Partnership

The Glasgow Partnership involves the National Health Service and the Glasgow Local Authority social services. Both agencies cooperate on a management and operational level to provide a combined approach to addiction services. They have established joint posts with dual accountability on service delivery, performance and governance. All NHS and local authority staff are co-located in a single locality teams, providing direct access.

Any service user presenting will firstly have relevant administrative details taken by administration staff. Using the information provided, the administration staff run a check to confirm that the service user is not already engaged with any other addiction services.

Using a standardised assessment sheet, professional staff conduct an initial assessment of the client's needs. Based on the assessment, an interim care plan is drawn up, identifying the first step in treatment and any crisis issues a client presents with.

Within a week, a specific care manager is assigned to the client. The care manager meets with the client and agrees a full care plan, outlining all interventions — clinical, housing, financial, training/employment, family supports — required to assist in the client's recovery. The care manager identifies and links to a key worker in each of the agencies providing an intervention for the client, including a key worker in the Partnership. These key workers are accountable to the care manager for providing their particular element of the care plan to the service user.

The care plans are stored on the Partnership's case management system. Key workers within the Partnership update the case file as appropriate. The care manager contacts the key workers in external agencies on a regular basis to assess the client's progress, and the care plans are amended accordingly.

The care manager reviews each care plan every three months, calling multi-agency meetings of the key workers, where appropriate, to assess progress.

Counselling

3.11 Counselling services may be provided as an integral part of treatment, but may also be provided in advance of, or in parallel with, other forms of treatment. Counselling provided in this context may help clients to understand their addictions, and to build up and maintain their motivation to persist with the appropriate treatment regime. Counsellors carry out an initial assessment of misusers' suitability for methadone maintenance programmes prior to the GP assessment, as well as providing therapeutic counselling interventions. This may overlap with the key worker role.

3.12 There are no set ratios of counsellors to drug misusers, or formal case-load targets. The HSE employs counsellors in all areas to assist persons with addictions, including alcohol and drug addictions. In the greater Dublin area, a total of around 51 whole time equivalent counsellors are available to assist those with drug addiction problems. A further 89 counsellors are employed in other areas, dealing with both drug and alcohol misuse cases.

3.13 HSE addiction services in all task force areas visited provide a counselling service. Voluntary and community groups also provide counselling services. In two of the task force areas visited, voluntary and community groups use unpaid students studying addiction counselling to provide a service for clients. The service is supervised by qualified counsellors.

3.14 The National Drugs Strategy envisaged that counselling services would be made available to drug misusers immediately following their presentation for treatment.[11] The effective target is to commence counselling within three days of presentation. The timeliness of access to counselling treatment is not formally monitored or reported on.

Quality Standards and Monitoring

3.15 The National Drugs Strategy required that the HSE, in consultation with the NACD, set quality standards for all State funded drug treatment and rehabilitation programmes and develop criteria to ensure that the treatment and rehabilitation services being delivered accord with the standards.[12] The implementation plan for the Strategy envisaged that national service standards and guidelines would be finalised and in place from 2005. This target was not achieved.

3.16 The requirement for quality standards for drug treatment and rehabilitation programmes was reiterated in the 2007 Working Group Report. The Working Group also recommended that all drug rehabilitation services should be subject to a periodic external evaluation process.

3.17 There is currently no national body that provides accreditation of addiction treatment services, or that carries out external monitoring of quality. The Methadone Treatment Protocol is a national standard that governs how methadone is prescribed and dispensed. National models of care or standards for other treatment types have not been put in place.

3.18 In the four HSE areas visited, service providers had their own policies and procedure documents in place outlining the provision of addiction services but these differed in terms of content and detail.

11 ***National Drugs Strategy 2001-2008***, Action 44
12 Action 50, ***National Drugs Strategy 2001-2008***.

3.19 In March 2008, the HSE commissioned a group to explore options for the phased introduction of benchmarked quality standards, to be implemented initially in residential addiction services directly managed or funded by the HSE itself. The group is taking into consideration pilot work already carried out on this issue by the HSE addiction services in the HSE Dublin Mid-Leinster area. The target was to have an initial draft report completed by end August 2008.

3.20 The group reported in December 2008 and recommended that the QuADs[13] benchmarking standards system be adopted as the standards of choice within both the HSE directly managed addiction services and voluntary services funded by the HSE. The report also recommended that the QuADs system should be introduced to all HSE areas by 2010 and once introduced they should then be subject to annual review by the addiction services management in each area. Following this, consultation should begin with the key voluntary organisations, funded by the HSE, to discuss the introduction of QuADs or a similar standard.

Outcome Monitoring

3.21 Up to now, there has been no mechanism for recording when or how treatment ends, which is a critical indicator of treatment quality and effectiveness. As a result, it is not possible to track treatment results at a programme or national level e.g. the percentage of treatments successfully completed; percentage dropping out during treatment, etc.

3.22 In 2007, the NDTRS piloted a revised case record format in the HSE South Eastern area, aimed at recording information about treatment results. Following evaluation, it is expected that the revised format will be adopted for use everywhere.

Conclusions

3.23 Achievement of a continuum of care in the delivery of treatment and rehabilitation depends on effective care planning and management systems, including arrangements for effective co-ordination between agencies. The planned national framework for care planning and management has not been developed.

> The national framework for care planning and management needs to be developed and implemented by the HSE.

3.24 In the absence of a national framework, care planning and management arrangements have developed in a piecemeal way. Good progress has been made in some areas in putting in place arrangements for the delivery of treatment and rehabilitation services on a continuum of care basis.

13 Quality in Alcohol and Drug Services (QuADs) - the organisational standards for alcohol and drug treatment services manual can be found at www.alcoholconcern.org.uk

In areas where coordination arrangements remain under-developed, there is scope to learn from good planning and management structures in areas with more advanced systems. Good practice opportunities identified during visits to local areas and service providers in other jurisdictions in the course of this examination include

- assignment of a care manager for each individual seeking treatment, to plan and oversee delivery of the full range of services required, including treatment, support and rehabilitation
- identification of a key worker in each of the service providers to ensure that the planned services are delivered for the individual
- an individual care plan, setting out the ultimate treatment objective and the planned progression for the individual, and identifying the services to be provided and the sequence and timing of their provision
- scheduled review of case progress and amendment of the plan in response to the individual's evolving needs
- timely availability of the planned treatments.

3.25 The operation of care planning needs to be regularly monitored and reported on.

The delivery of care planning needs to be managed on the basis of clear performance targets for care planning, with regular monitoring and reporting of achievement. The performance indicators used in framing targets should include

- the percentage of clients in each area for whom care plans have been adopted
- timeliness targets for drawing up of individual care plans and for case reviews
- target ratios between clients and key workers and case managers.

Periodic reviews of the quality of care planning should also be undertaken and reported.

3.26 There appears to be a risk of overlap in the services provided by counsellors and caseworkers.

The respective roles of counsellor and key worker/case manager should be clarified to ensure that there is no duplication of function. The extent of provision of counselling services for persons presenting for treatment for drug addictions should be formally monitored and reported on.

3.27 In the past, the NDTRS focused on recording admissions to treatment. Its further development to capture the outcomes of each course of treatment would significantly improve the quality of information about treatment and rehabilitation services.

Targets should be set in relation to the expected outcomes of treatment and rehabilitation services. Service outcomes should be recorded and monitored through the NDTRS and be regularly reported on.

4 Treatment of Opiate Addiction

4.1 Heroin is the most commonly misused of the opiate group of drugs. The general nature of addiction and the many consequences of prolonged use of heroin have resulted in the development of a complex treatment and harm reduction system. This includes

- needle exchange services for active users, designed to reduce the incidence of equipment sharing, and of consequent cross infection
- provision of substitute drugs — mainly methadone — aimed at stabilising the misuser's situation, and subsequently, where feasible, at reducing the level of drug dependence
- detoxification of misusers who have reduced their drug dependence to an appropriate level, through incremental reductions in the quantity of drugs used, until drug taking is eliminated
- residential rehabilitation programmes for those who are abstaining from drug use
- aftercare support for persons who have successfully completed rehabilitation.

At any stage in the course of treatment, there is a significant risk of relapse, which may result in full resumption of drug misuse, or reversion to an earlier stage of treatment.

4.2 This chapter examines access to treatment for heroin addiction, in terms of level of provision and timeliness of access. It also looks at how the effectiveness of treatment is evaluated.

Provision of Treatment

Needle Exchange

4.3 Many drug users contract blood-borne viral and other soft tissue infections through unsafe drug using practices. Research studies from the period 1995 to 2004 indicated that one in ten injecting drug users were HIV positive, one in 20 were hepatitis B positive and between 60% and 70% were hepatitis C positive. The purpose of needle exchange services is to prevent the spread of such diseases amongst misusers and to individuals in the wider community, who may be at risk from discarded injecting equipment.

4.4 There is no reliable estimate of the numbers of current injecting drug users in Ireland. However, more than half of injecting drug users entering treatment in 2007 reported that they had shared injecting equipment at some point in their life.[14]

4.5 The National Drugs Strategy mid-term review recommended an increase in the access to and availability of harm reduction services, including needle exchange.

4.6 Needle exchange has been available since the early 1990s in the greater Dublin area, where the injecting problem is greatest (see Figure 4.1). The only additional needle exchange services established during the National Drugs Strategy term were in

- the Mid-West, where services were established in two areas in 2005
- the Midlands, where services were established in two areas in November 2008.

14 National Drug Treatment Reporting System

Figure 4.1 Availability of needle exchange services, by HSE area

HSE Area	Number of areas serviced end 2008	First established	Number of needle exchange encounters	Intravenous drug users entering treatment in 2007[a]
Eastern region areas				
East coast	6	1991	2,914	376
Northern	7	1989	3,516	1,120
South western	7	1989	39,026	1,140
Other areas				
Mid west	2	2005	209	83
Midlands	2	2008	—	113
North east	—	—	—	182
North west	—	—	—	26
South	—	—	—	105
South east	—	—	—	240
West	—	—	—	55

Source: Department of Community, Rural and Gaeltacht Affairs

Note: a Data from the NDTRS is included as a rough indicator of injecting drug use in each area as the number injecting and/or number availing of needle exchange is not recorded.

Exchange is not available in the North East and South East areas, where there is a significant problem of drug injecting, as indicated by the numbers of intravenous drug users entering treatment.

4.7 The opening hours of needle exchanges also has an impact on availability of services. The mid-term review of the National Drug Strategy recommended that the needle exchanges would be open at evenings and weekends, according to the need in every local health office area. In two of four HSE areas visited, an exchange service is not available after normal office hours.

4.8 Best practice guidelines on the operation of needle exchanges have not been developed. The exchange of equipment occurs in a number of settings. In some areas, HSE staff handle the exchange exclusively in HSE facilities (e.g. drug treatment centres). In other areas, the HSE needle exchange services are supplemented by exchanges operated by community and voluntary groups, with staff of the groups trained by the HSE. HSE outreach staff in one area visited during this examination operate a 'back-pack' needle exchange service in areas where there is a known but limited demand for the service. This involves the staff meeting misusers at an agreed time and place each week. This practice is not widespread.

4.9 Injecting misusers are not required to register or to provide personal details to avail of needle exchange services. As a result, the numbers of individuals accessing treatment is not known.

4.10 Users of the needle exchange service are supplied with clean injecting equipment and boxes for disposal of used equipment, in exchange for used equipment. The service also provides an opportunity for outreach workers to discuss health issues with the misuser and refer them to services, including drug treatment, that they might require. Rates of progression to treatment for addiction are not known.

Methadone Treatment

4.11 Methadone is widely used as a controlled substitute for heroin. It is generally used in one of two ways

- For short-term detoxification from opiates
- For longer-term methadone maintenance.

4.12 The initial phase of methadone maintenance treatment (over about six weeks) usually involves stabilising the misuser on a regular daily dose of the drug. Misusers are generally required to attend at a clinic and to take the methadone under the supervision of a doctor, nurse or pharmacist. Regular checks (e.g. weekly urinalysis) are carried out by medical staff to monitor drug use. Once a stable situation has been achieved, the misuser may be permitted to take away a few days supply of methadone at a time.

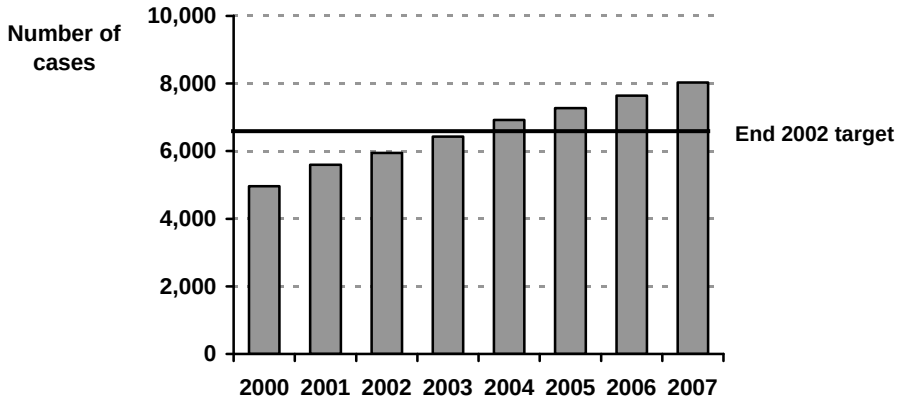
4.13 Methadone maintenance treatment potentially allows misusers to derive greater benefit from other interventions, such as counselling and treatment for medical conditions. It can also create circumstances where treatment for the underlying addiction may be considered, both by the prescribing GPs and the misusers themselves. Preparation for treatment involves graduated reduction of the methadone dose. For a variety of reasons, not all misusers are suitable for a drug reduction approach. In those cases, permanent treatment with methadone may be the more appropriate outcome.

Methadone Treatment Places

4.14 The National Drugs Strategy included a target of having a minimum of 6,500 methadone treatment places by the end of 2002. It did not project treatment capacity beyond that date.

4.15 The best available indicator of the number of methadone treatment places is the number of individuals in treatment at a point in time. At the end of 2007, the total number of persons in treatment was around 8,000 i.e. 20% over the end 2002 target (see Figure 4.2).

Figure 4.2 Numbers receiving methadone treatment at end of year, 2000 to 2007



Source: Central Treatment List and the National Drug Treatment Reporting System

4.16 Most recipients of methadone are on long-term methadone maintenance. However, a significant number of individuals receive methadone in short-term courses of detoxification. As a result, the total number treated in a year will exceed the number of treatment places. In 2007, a total of around 9,800 received methadone treatment.[15]

4.17 Heroin misuse has predominantly been a problem in the greater Dublin area, and the bulk of the methadone treatment services are also located in the region. An increase in the numbers treated with methadone outside the Eastern region — from around 230 in 2001 to over 1,000 in 2007 — reflects both increased availability and misuse of heroin outside Dublin, and the establishment of new services to meet local needs.

Treatment Delivery

4.18 HSE addiction services provide methadone maintenance services in local clinics and through specially trained community GPs and pharmacies. The clinics are staffed in most instances by GPs employed by the HSE but some clinics are provided by private GPs who are paid by the HSE for each session. A mobile clinic is used to dispense methadone in some areas of Dublin where sufficient pharmacy capacity is not available.

4.19 Figure 4.3 shows the numbers of clinics, GPs and pharmacists in the methadone protocol in each HSE area and the numbers of clients for whom they provide a service. In the North East and North West areas, there are no clinics providing a methadone service. Clients in those areas are required to register with a GP to receive methadone.

Figure 4.3 Methadone maintenance providers by HSE area, 2007

HSE Area	Service providers			Service Users
	Clinics	GPs	Pharmacists	
Greater Dublin				
East coast	13	30	55	907
Northern	24	56	93	3,501
South western	24	109	113	4,048
Other areas				
Mid Western	1	11	23	170
Midlands	2	8	34	233
North Eastern	—	7	56	273
North Western	—	5	10	22
South Eastern	2	6	31	171
Southern	1	7	17	89
Western	1	16	38	80
Total	**68**	**255**	**470**	**9,494[a]**

Source: HSE and Central Treatment List

Note: a The total figure on the Central Treatment List for 2007 was 9,756. However, this includes 262 people in treatment where HSE area is not recorded.

15 Reliable data are not available on the breakdown between those receiving detoxification and those receiving methadone maintenance treatment.

4.20 At the end of 2007, around 36% of those on methadone maintenance were under the supervision of community-based GPs. These are trained under the HSE's Substance Misuse Programme to two standards

- Level I qualification under the programme allows GPs to maintain methadone treatment for misusers who have previously been stabilised on a methadone maintenance programme. Each GP qualified at this level is permitted to treat a maximum of 15 stabilised misusers.
- Level II qualification allows GPs both to initiate and maintain methadone treatment. Each GP qualified at this level may treat up to a maximum of 35 misusers. Practices where two qualified level II GPs are practicing are permitted under the protocol to treat a maximum of 50 misusers.

4.21 The National Drugs Strategy required the HSE "… to consider as a matter of priority, how to increase the level of GP and pharmacy involvement in the provision of treatment programmes." While a high number of GPs are involved in the community methadone scheme in some areas, there has been a difficulty in attracting GPs in other areas into the scheme due to the profile of the service user group, fear of local opposition and the need for specialist training. Access to psychiatric services for patients under GP supervision is also an issue in some areas. In order to expand GP capacity, some HSE areas have arranged for the use of community and voluntary groups' premises as prescribing clinics. This has the benefit of providing the GP with premises outside his/her own practice, while also attracting misusers to access additional services from the hosts. An important factor in developing such additional capacity has been consultation with the local community.

Cost of Methadone Treatment

4.22 The cost of provision of methadone maintenance treatment in HSE and Central Drug Treatment Board clinics cannot readily be separated from the cost of provision of other services.

4.23 The total cost of primary-care based methadone maintenance treatment in 2007 was around €14 million. Of this total, fees to GPs amounted to almost €5.3 million. Fees to community pharmacists were €5.9 million, and the cost of ingredients was a further €2.8 million.

Detoxification

4.24 Because of the severe withdrawal symptoms that are associated with addiction to heroin and other opiates, misusers who want to become drug-free generally need to undergo a course of detoxification. This involves progressive withdrawal of drugs, including methadone, under close medical supervision. Other medication is prescribed to relieve withdrawal symptoms. Typically, the detoxification programme lasts about six weeks.

In-Patient Detoxification

4.25 The HSE currently funds two hospital in-patient detoxification units, which between them have a total of 23 beds. These are

- a ten-bed unit in Beaumont Hospital
- a 17-bed unit in Cherry Orchard Hospital, but with a staffing level that permits only 13 beds to operate.

These beds are used only to treat patients for opiate or benzodiazepine use. No detoxification facilities exist for other drug dependencies. The HSE estimates the total cost of running the two detoxification units at €2.7 million in 2007.

4.26 Some of the beds in the two detoxification units are also used to stabilise misusers in crisis situations e.g. during the late stages of pregnancy. The HSE estimate that the equivalent of 5.5 of the beds (24% of the total bed capacity) are used for such stabilisation patients. This reduces the hospitals' capacity to provide a detoxification service.

4.27 Residential detoxification capacity in the health service has not expanded since the National Drugs Strategy was adopted. However, the issue of capacity was considered by the Working Group on Drugs Rehabilitation and by a later Working Group on Residential Treatment and Rehabilitation. The latter concluded that a total of 63 beds are required for medical detoxification and stabilisation of drug users i.e. 2.7 times the current number of in-patient beds.

4.28 Based on a six-week detoxification programme cycle, the maximum number of courses of in-patient detoxification treatment that can be provided is 8.7 per bed per year. However, normal gaps between programmes, patients dropping out, cleaning/renovations, etc. all reduce the effective capacity.

4.29 Neither the HSE nor the hospitals have set target capacity utilisation rates for the detoxification units in Beaumont or Cherry Orchard hospitals. Capacity utilisation rates are not routinely monitored by the HSE as a performance indicator.

4.30 In 2007, only around two-thirds of the available bed days in the two facilities were used for treatment. Discounting the beds generally used for substitution treatment, this implies that, at most, 90 to 100 full courses of in-patient detoxification could have been provided.

Community-Based Detoxification

4.31 In addition to the hospital-based detoxification facilities, there is also a community-based detoxification facility in Dublin with a total of six beds and a maximum annual capacity of 52 patients. Treatment is provided in this facility for patients who are deemed by their GP to be suitable for detoxification without hospital in-patient medical support. Medical staff are attached to the unit, and the patients' own GPs are also involved in their care.

Residential Rehabilitation

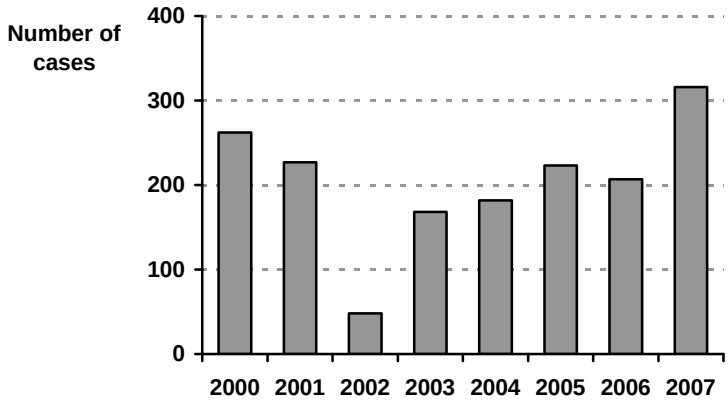
4.32 In most cases, the objective of following a course of detoxification from heroin or methadone is to prepare a patient for participation in a residential rehabilitation programme. This is usually provided on condition that participants are no longer using drugs or substitutes and remain drug-free throughout the programme.

4.33 Most of the available residential rehabilitation programmes are provided by community and voluntary groups, which together have a combined capacity of 634 beds. 197 beds are available to alcohol misusers only and the remaining 437 beds are available to cater for problem drug or alcohol users.

4.34 The rehabilitation programmes offered by treatment providers use different approaches e.g. therapeutic communities, 'twelve steps' and cognitive behavioural therapy. The duration of the programmes varies from four weeks to six months, but most of the residential centres provide four to six week programmes. Most programmes include aftercare support for up to two years after completion of the programme.

4.35 NDTRS data indicates that around 200 to 300 opiate misusers are admitted each year to residential rehabilitation programmes (see Figure 4.4). Drop-out and programme completion rates are not known.

Figure 4.4 Number of opiate misusers entering residential rehabilitation programmes, 2000 to 2007



Source: National Drug Treatment Reporting System

Waiting Times

4.36 The nature of addiction to heroin and the sequence of treatments usually required mean that delays in being assessed and in the provision of treatment increase the already substantial likelihood that patients may lose their resolve to start treatment or will resume their misuse. Consequently, waiting time for assessment and treatment is a key performance issue.

Waiting for Assessment

4.37 One of the stated objectives of the National Drugs Strategy was that drug misusers should have immediate access to professional assessment and counselling by HSE services. While the term 'immediate access' was not formally defined in the strategy, it is generally accepted by service providers that this means that the professional assessment will be undertaken within three working days of referral or presentation by the misuser, and that counselling will commence at the same time.

4.38 Of the opiate cases recorded by the NDTRS for 2007, an estimated 61% were reported to have been assessed within three days. Almost one in eight of those assessed were reported to have waited more than a month for their assessment.

4.39 The visits to service providers during this examination suggest that the NDTRS figures may underestimate the extent of waiting for assessment. The practice in some areas is that NDTRS recording starts at the time of assessment, rather than at the time of presentation. Some service providers also operate informal waiting lists, calling those on the list when an assessment appointment becomes available. In addition, where misusers are aware of long waiting times for access to local services, they may be deterred from presenting for assessment.

Waiting for Methadone Treatment

4.40 The National Drugs Strategy also included a target that treatment would commence not later than a month after assessment. It recognised that that target was not being met at the time the Strategy was being developed. The subsequent implementation plan envisaged the time target being achieved by 2005 at the latest.

4.41 Of the opiate misuse cases recorded by the NDTRS for 2007, an estimated 82% were reported to have commenced methadone treatment within a month of assessment. Around 88% of opiate misusers seeking another form of treatment were reported to have commenced within the one-month target.

4.42 While a high proportion of individuals commence treatment within the one-month target, an examination by the HSE of the waiting lists in April 2008 revealed that there were approximately 460 people waiting for methadone treatment. Average waiting times for those on the lists in some areas were over a year (see Figure 4.5).

4.43 Waiting time for methadone treatment was longest in the Southern, Midlands and South-Eastern areas where individuals were reported to have been waiting for between 13 and 18 months for treatment. The reasons for the long waiting times in these regions may, in part, reflect the initial impact of the establishment of new methadone maintenance treatment services locally, resulting in previously hidden demand coming to light.

4.44 When this report was being finalised the HSE stated that it produces quarterly data on the numbers waiting for methadone treatment. It is now considering the adoption of a standard definition and national protocol concerning the criteria for waiting time calculation to simplify performance indicator recording. The Dublin Addiction Information System (DAIS) is being developed with the assistance of the HRB to address this matter on a pilot basis.

Figure 4.5 Average waiting times for methadone treatment, by HSE area, as at April 2008

HSE Area	Number of people	Average wait (months)
Greater Dublin		
East Coast	26	0.6
Northern	14	0.5
South West	65	1.4
Drug Treatment Centre Board	38	3.8
Other areas		
Midlands	96	13.9
Mid-West	4	2.3
North Eastern	35	5.5
North Western	-	-
South Eastern	68	13.5
Southern	100	18.0
Western	15	3.0
All areas	**461**	**9.9**

Source: HSE

Waiting for Detoxification

4.45 A person who wishes to move from methadone maintenance to detoxification will usually need to have his/her methadone prescription reduced in a structured way to the threshold level required for a detoxification programme. This process is usually carried out under the supervision of the prescribing GP and typically takes 10 to 21 days. This is considered to be an assessment process for entry to the detoxification. Out of consideration for the patient, the general practice is not to commence the methadone reduction/assessment process until access to a place on a detoxification programme is in prospect. As a result, delays in the provision of detoxification may not become apparent, because they are absorbed instead into extended duration of methadone maintenance treatment.

Evaluation of Effectiveness

4.46 The ultimate objectives of treatment are to change the behaviour of drug misusers and to improve their health. Evaluating the extent to which such objectives are achieved as a result of treatment is challenging, but there are many examples internationally of evaluations of treatment programmes. Some evaluation studies have also been carried out on Irish treatment programmes.

4.47 The NACD commissioned a large-scale longitudinal study of the outcomes achieved for a sample of persons entering treatment for opiate addiction with a range of service providers in 2003/2004. Baseline interviews were carried out with 378 persons entering treatment. A further 26 individuals using needle exchange services were also interviewed, bringing the total number of respondents to 404.

4.48 The study team carried out follow-up interviews with as many of the original participants as possible after a year and again after three years. The rate of response for both rounds of the follow-up interviews was high, and was significantly better than response rates for similar studies carried out elsewhere.

- at one-year follow-up stage 75% of respondents were re-interviewed
- at three-year follow-up stage 88% of respondents were re-interviewed.

4.49 Participants in the study were asked during each interview about

- their recent/current use of drugs, including opiates, other illegal drugs and alcohol
- recent involvement in crime
- general health (physical and mental)
- employment and accommodation.

4.50 The study found that the level of retention in treatment was high with 69% of respondents in treatment at the three-year follow-up (some may have dropped out and re-entered). Of those still in treatment, 86% were on methadone maintenance treatment. The report also found that there had been reductions among those interviewed in the reported rates of illicit use of drugs and of involvement in crime, and increased rates of employment and independent living. No significant improvement in health status was noted. (See Figure 4.6.)

Figure 4.6 Key Findings of the Research Outcome Study in Ireland (ROSIE)

Abstinence from drugs – There was a significant increase observed in the percentage of individuals reporting abstinence from all drugs (excluding alcohol and prescribed methadone) at the three-year follow-up (29%) when compared with intake (9%).

Drug use – There were significant reductions in the percentage of participants reporting drug use in the preceding 90 days.

Type of drug	Percentage reporting usage of drug in the preceding 90 days	
	2003/2004	2006/2007
Heroin	77%	46%
Cannabis	64%	49%
Cocaine (including crack)	48%	22%
Non-prescribed benzodiazepines	44%	32%
Non-prescribed methadone	41%	14%
Alcohol	54%	44%
Poly-drug use	76%	46%

Risk behaviour – The proportion of respondents reporting current injecting of drugs decreased significantly.

	2003/2004	2006/2007
Injected any drug in the last 30 days	44%	27%

Employment and accommodation – There was an increase in the percentage of respondents that were currently employed and an increase was also noted in the percentage of respondents living independently in the previous 90 days.

	2003/2004	2006/2007
Currently employed	16%	29%
Living independently in own house/flat or rental accommodation	34%	49%

Physical and mental health outcomes – the results for a range of physical and mental health symptoms were mixed with no clear positive outcomes emerging for the respondents.

Source: Dr. Catherine Comiskey, Paul Kelly and Dr. Robert Stapleton, ***Research Outcome Study in Ireland: A Summary of three-year outcomes***, supported by NACD, October 2008

Conclusions

4.51 There has been a steady increase in the provision of methadone treatment over the period covered by the National Drugs Strategy. At end 2007, just over 8,000 people were receiving treatment. There has also been some increase in the provision of needle exchange services but gaps still remain in service provision.

4.52 Admissions to detoxification and rehabilitation treatment of those with opiate misuse problems are very low, when compared to the numbers receiving methadone treatment. For example, it is estimated the annual level of detoxification treatment is in the region of 100 courses of treatment at most – around 1.25% of those receiving methadone treatment. The rate of admission of opiate misusers to rehabilitation programmes in 2007 was less than 4% of the number of individuals on methadone treatment. The potential for progression from one form of treatment to another clearly depends on the particular circumstances of each individual case.

The HSE should consider setting national target progression rates for those seeking or receiving treatment for opiate addiction. If this were done, treatment and rehabilitation capacity planning could then be based on what is required to meet the targets.

4.53 From the point of view of a person seeking treatment for an addiction problem, timely response is important, and the most important measure of timeliness is the time that elapses from initial presentation for treatment, until treatment commences. No target has been set in relation to that measure. Separate targets have instead been set for

- the period from presentation for assessment until the assessment is carried out (3 days)
- the period from completion of assessment to start of treatment (1 month).

4.54 The NDTRS data indicates that the waiting time targets set have not been achieved for all opiate misuse patients, but that a substantial proportion of patients are assessed and treated within the targets.

A target should be set for the elapsed time between initial presentation and commencement of treatment.

4.55 Accurate recording of the time of first presentation for treatment is essential. This does not take place in the case of some clients.

The HRB needs to put more emphasis on ensuring that all service providers comply with the existing NDTRS protocols for recording information.

4.56 Evaluation of the effectiveness of treatment for addiction is complex. Nonetheless, some sound and informative work has been done in relation to treatment of opiate addiction in Ireland.

The NACD should consider a further follow-up on the respondents to the ROSIE study to identify the long-term outcomes for those that receive treatment for opiate addictions.

Consideration should also to given to commencement of another longitudinal study of a new cohort of individuals presenting for treatment for opiate addiction, along the lines of the ROSIE study. This would help identify the extent to which current treatment and rehabilitation services are effective for opiate misusers presenting for treatment now.

5 Treatment of Non-Opiate Addiction

5.1 Excluding opiates and alcohol, the most commonly reported problem drugs among those entering treatment for drug misuse were cannabis, cocaine, and stimulants. A significant number of people also seek treatment for misuse of prescription drugs, such as benzodiazepines. The effects of the drugs are varied, and the typical user groups are quite different.

5.2 The prevalence of cannabis and cocaine use among the general population is increasing. Cannabis is the most commonly used illegal drug in Ireland. The proportion of adults who reported using cannabis at some point in the preceding year increased from 5% in 2002/2003 to 6.3% in 2006/2007. Cocaine use is more limited but is increasing at a rapid rate. For example, the proportion of adults who reported using cocaine (including crack cocaine) at some point in the preceding year increased from 1.1% in 2002/2003 to 1.7% in 2006/2007.

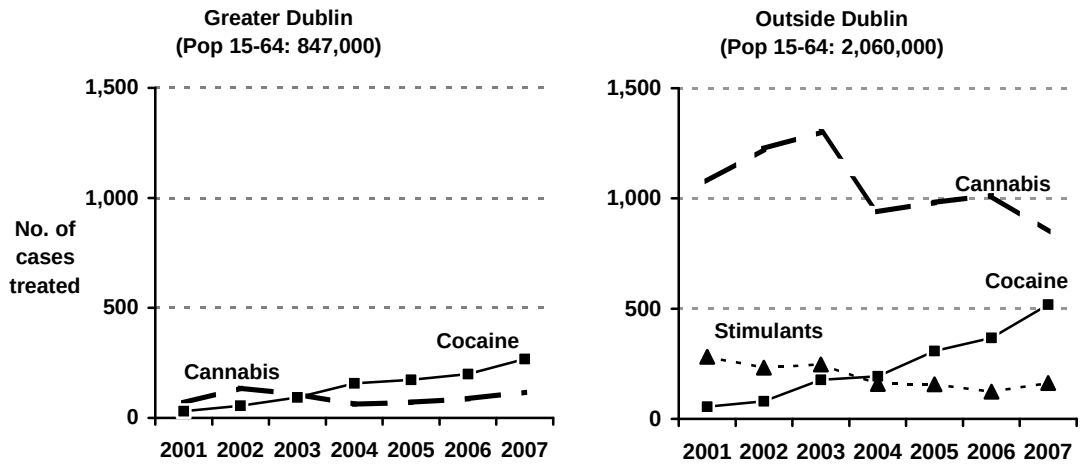
5.3 Polydrug addiction is also increasing. Changes in the pattern of drug misuse creates a challenge for service providers to change from a system that is geared predominantly to dealing with one drug type (e.g. heroin addiction in the greater Dublin area), to one that is capable of dealing with different kinds of addiction and with clients with multiple addictions.

5.4 The impacts of misuse of non-opiate drugs may not become apparent as quickly as with heroin addiction. As a result, misuse of non-opiates may continue for a protracted period before the misuser presents for treatment.

Provision of Treatment

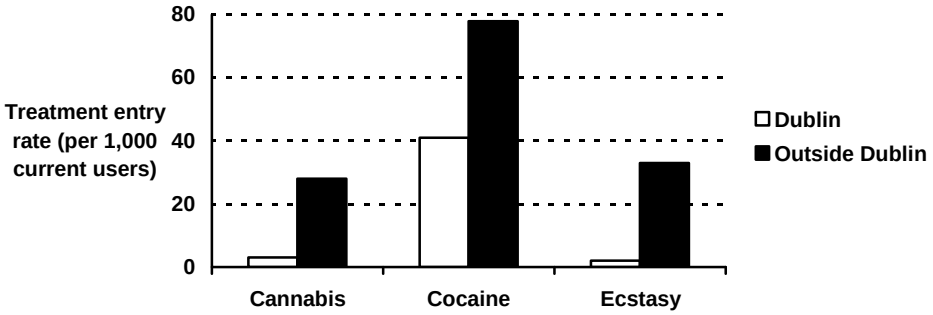
5.5 Figure 5.1 shows the number of persons treated for addiction each year from 2001 to 2007, where cannabis, cocaine and stimulants were the primary problem. The numbers treated in the greater Dublin area and in other areas of the country are shown separately.

Figure 5.1 Number of persons treated for non-opiate addictions, by type and place of residence, 2000 to 2007[a]



Source: National Drug Treatment Reporting System
Note: a Excludes cases where area of residence is not recorded. Numbers entering treatment for stimulant misuse in Dublin are small, and so are not shown.

Figure 5.2 Numbers entering treatment as a proportion of current users, 2007



Source: Analysis of the Comptroller and Auditor General

5.6 Although there is a higher prevalence of misuse of all kinds of non-opiate drugs in the greater Dublin area than elsewhere, the rate at which users of non-opiate drugs in Dublin enter treatment appears to be significantly lower than for the population elsewhere. When the number entering treatment is related to the numbers reporting use of each drug type in each area, the scale of the difference in the rate of access to treatment becomes more apparent (see Figure 5.2).

5.7 The apparent difference in the rate of access of treatment may have arisen for a range of reasons. There may be differences in the pattern of drug misuse in greater Dublin and in other areas, but this is unlikely to account for a large part of the variation. The more likely cause is a difference in the provision of treatment between areas, such as the relative priority given to heroin addiction treatment in Dublin.

5.8 In some areas of Dublin, treatment services for non-opiate addiction are provided in the same facilities where heroin misusers are treated. Some service providers believe that non-heroin misusers may be reluctant to present for treatment along with heroin misusers due to the perceived stigma. They may also be deterred in some cases by the behaviour of other clients.

5.9 The HSE has stated that it is aware of the variation in the recorded rate of access to treatment and is addressing possible under-reporting by developing a more comprehensive reporting system.

Types of Treatment

5.10 Cognitive behavioural therapy and counselling-based treatment are the most usual forms of treatment for non-opiate addiction. These are generally provided on an out-patient basis. Clients may attend one or more sessions, with the number of sessions reflecting the clients' needs (e.g. to accommodate work and family commitments) and their willingness to engage with the treatment.

5.11 More structured rehabilitation programmes for non-opiate addiction may also be provided, on an out-patient or residential basis. These programmes vary in duration and approach. The main treatment models are the therapeutic community approach – which involves an intense confrontational form of group therapy often over an extended period – and models of treatment derived from the 12-step approach to dealing with alcohol dependence, which are usually of shorter duration and less personally challenging. The suitability of a treatment model for an individual must be carefully assessed, taking account of the particular circumstances of each case.

5.12 Based on the number reported entering treatment each year, there has not been a significant increase in the supply of treatment for users of non-opiate drugs. For example,

- around 1,200 to 1,400 persons commenced counselling treatment each year between 2004 and 2007.
- around 400 to 470 persons each year were reported to have entered other courses of therapy for non-opiate drug addiction. Just over half of those treated received treatment on a residential basis, and half in out-patient programmes.

Cocaine Treatment Initiatives

5.13 In response to the increase in the rate of cocaine misuse, the Department of Community, Rural and Gaeltacht Affairs established a sub-group of the NDST in 2004 to look specifically at the cocaine problem, and how it should be tackled. The sub-group drew up an initial plan with two main elements. These aimed

- to deliver training to staff in treatment centres on how to treat those misusing cocaine
- to initiate pilot projects targeted at four different cocaine misuser groups, to try to establish what form cocaine treatment programmes should take.

Funding of €400,000 was approved for the initiatives and for the pilot projects. A summary of the initiatives is given in Figure 5.3.

5.14 In 2006, a further six cocaine projects proposed by local drug task forces were approved for funding on an interim basis. The amount allocated for the projects was €421,000.

Figure 5.3 Cocaine treatment initiatives

Staff Training

In 2004, the NDST funded Merchants Quay Ireland to co-ordinate training programmes for service providers who come in contact with cocaine users. The training programmes were implemented from May 2006 and comprised

- a one-day course delivered to three groups of front-line staff (completed by 53 participants)
- a three-day course delivered to two groups of key or case workers (completed by 38 participants)
- a two-day course delivered to four groups of counsellors in HSE and voluntary organisations (completed by 21 participants)

The HSE, in partnership with the Waterford Institute of Technology, has also established a National Addiction Training Programme. The programme will have an initial focus on cocaine addiction training.

Pilot Treatment Schemes

Four pilot projects to examine the effectiveness of treatment for cocaine misuse among groups of misusers with different characteristics were undertaken in the greater Dublin area.

- **Intravenous cocaine users** — a pilot project was undertaken to evaluate two treatment models: contingency management and cognitive behavioural therapy. Training of 21 qualified counsellors was completed but to date, there has no been no evaluation of their subsequent work.
- **Polydrug users of cocaine** — the planned treatment interventions with polydrug users envisaged a combination of individual and group counselling and cognitive behavioural therapy approaches. However, this was modified at the implementation stage. Participants were invited to join a group-counselling programme consisting of a 90-minute session each week for 12 weeks. A post-programme evaluation identified a number of significant weaknesses in the project design and implementation that needed to be addressed but found that this approach to cocaine treatment had some merit.
- **Recreational users of cocaine —** a pilot community-based project was conducted in Tallaght targeting users who snort cocaine powder, generally in social settings. The objective of the pilot was to identify the most appropriate methods of attracting those with problem cocaine use into services. The planned interventions included advertising service availability, relationship building, individual care plans, individual counselling and complementary therapies. The cocaine treatment service was promoted through a media campaign and proactive outreach work. An evaluation of the project was carried out in April 2006. The evaluators concluded that the project was effective and very good value for money and the project has continued to run.
- **Women working in the sex industry who use cocaine —** It was originally envisaged that the project would train participants to provide information on sexual health and drug use to their peers but this was not achieved. The project changed its original strategy to one focused on outreach, whereby participants in the programme were encouraged to invite other women to information and/or complementary therapy sessions. The project commenced in October 2005. During the project, it was observed that many of the women had complex social and medical problems and that the project activities were not broad enough to address such issues. The outreach worker addressed some of these problems through referrals to and negotiations with other services. The effectiveness of the programme was evaluated, but the evaluation was unable to conclude on whether the programme was worthwhile. The Department of Community, Rural and Gaeltacht Affairs have stated that the key finding is that a holistic approach is required with this marginalised group.

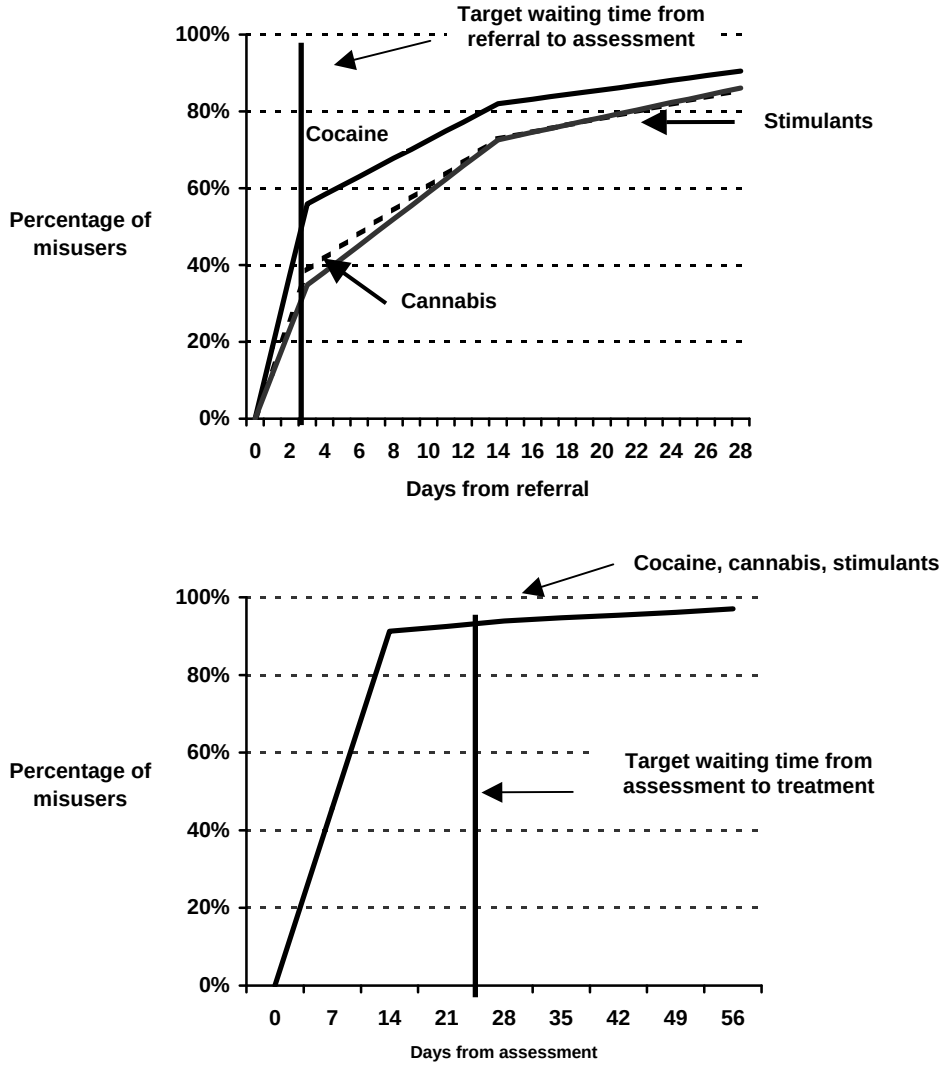
Waiting for Treatment

5.15 The target waiting times for assessment and treatment set in the National Drugs Strategy were established in a context where opiate addiction was perceived to be the greatest problem to be tackled. However, the targets do not differentiate between opiate and non-opiate drug addiction. Consequently, the effective target in relation to non-opiate addictions is in all cases to carry out an assessment within three days of presentation for treatment, and to commence treatment within one month of assessment.

5.16 The information submitted in returns to the NDTRS indicates that the time target for access to assessment were not met in 2007 (see Figure 5.4). Overall, assessment of cocaine misusers (56% within the three-day target) appears to have been more timely than assessment for cannabis or stimulant misusers (less than 40% within the three-day target).

5.17 Based on the cases reported to the NDTRS in 2007, treatment for non-opiate addiction was provided in almost all cases within the target one month waiting period.

Figure 5.4 Timing of assessment and treatment for non-opiate addictions, 2007



Source: National Drug Treatment Reporting System

Outcomes of Treatment

5.18 The outcomes of treatment for non-opiate addiction at a national level are not known. The 2007 Report of the Working Group recommended that the NDTRS should be developed to provide enhanced tracking and monitoring of problem drug users as they progress through treatment and rehabilitation.

5.19 A pilot NDTRS outcome capture study in the South East region has yielded some information about the results of treatment delivered to a group of individuals treated for non-opiate addiction in the region. Of 358 cases that completed treatment in 2007, it was found that 42% of those treated completed the planned or expected treatment. Those that dropped out from a treatment programme did so for a variety of reasons.

- Around 25% of those treated dropped out through refusing treatment sessions or missing appointments.
- 18% stopped treatment because they considered themselves stable.
- 9% were transferred to another treatment provider.
- Treatment was withdrawn from 6% of those that entered programmes because of non-compliance with the treatment programme.

5.20 The outcome capture study asked service providers to indicate whether or not each participant in a treatment programme has achieved stability at the time they left treatment, in that they had responded to treatment. In response, the service providers reported that around three quarters of those treated were considered stable on exit from treatment, and around a quarter were considered to be unstable on exit.

5.21 No formal large-scale studies of the effectiveness of treatment programmes for non-opiate addictions have been carried out in Ireland.

Conclusions

5.22 Despite the evidence of increased use of non-opiate drugs over the life of the National Drugs Strategy, there does not appear to have been a commensurate increase in the number of cases treated for problem use of non-opiate drugs. However, there is some evidence of a shift in the type of problem treated, with a relative decline in the numbers treated for cannabis misuse and a relative increase in the number treated for cocaine misuse.

> The existence of significant problems of misuse of drugs other than opiates needs to be recognised in planning for addiction treatment. Targets should be set in relation to the supply and timeliness of treatment for the various kinds of non-opiate addictions.

5.23 The available information suggests a significant difference between those resident in the greater Dublin area and those resident elsewhere in the rate at which problem users of non-opiate drugs access treatment. This may reflect a greater priority given to treatment for opiate use in Dublin.

Changes in the pattern of drug use since 2001 suggest that there are, in effect, two separate contexts in which drug treatment has to be provided

- a largely opiate-based addiction problem, concentrated in certain marginalised and poor sectors of society, and in certain geographic areas
- problem use of non-opiate drugs, spread more widely across social groups and geographic areas, and where those being treated may have access to more social supports and economic resources.

While there may be overlaps between the two populations of drug users, the management of service delivery may require differentiation in targets set, performance measures used and performance reporting.

5.24 The recorded waiting time for assessment for those presenting for cocaine misuse problems is similar to the waiting time for assessment for opiate misuse treatment. Those presenting for treatment for misuse of other illegal drugs appear to wait longer for assessment. There is, however, a risk that the number presenting for treatment is under-reported.

The completeness and accuracy of information recording needs to be reviewed in order to identify to the extent of possible under-recording or late recording of those presenting for treatment, so the true extent of waiting for treatment may be gauged.

5.25 In regard to treatment provided, more information is needed about its nature, duration and outcome. A planned widening of the scope of the NDTRS to capture information about treatment given and the outcomes of treatment should address this concern.

While it is recognised that a formal, longitudinal study along the lines of the ROSIE study would be more difficult to carry out for those treated for non-opiate drug use, the effectiveness of treatment for non-opiate addictions needs to be formally evaluated in order to inform the design of treatment programmes.

5.26 Significant resources have been invested in pilot schemes with the aim of identifying the best approaches to provision of treatment for problem cocaine use.

The evidence from these pilot projects needs to be distilled in order to identify effective treatment approaches. The most effective approaches could then be taken into account in designing national treatment capacity and set target outcomes for publicly-funded programmes to tackle problem cocaine use.

6 Addiction Treatment in the Criminal Justice System

6.1 Many users of illegal drugs, and in particular heroin users, end up in contact with the criminal justice system.[16] This creates many challenges for the criminal justice system, including provision of necessary medical and psychological services, and preventing drugs supply in places of detention. However, contact with the criminal justice system also potentially provides a period of relative stability for some drug misusers and opportunities for the provision of structured treatment.

6.2 This chapter looks at drug addiction treatment for persons under the supervision of the Prison Service and the Probation Service. It also outlines the role of the Drug Treatment Court which operates in north inner city Dublin. The focus of the chapter is on access to services, waiting time for treatment, and evaluation of effectiveness.

Addiction Treatment in Prison

6.3 The range of addiction treatment provided varies from prison to prison, as indicated in Figure 6.1.

Figure 6.1 Drug addiction treatment services in Irish prisons, August 2008

Prison	Average number of prisoners in 2007	Treatment type ('●' = service available; '—' = service not available)			
		Addiction counselling	Methadone maintenance	Detoxification	Rehabilitation
Mountjoy [a]	518	●	●	●	●
Midlands	442	●	●	●	—
Cloverhill [a]	418	●	●	●	—
Wheatfield [a]	376	●	●	●	—
Limerick	296	●	●	●	—
Cork	264	●	—	—	—
Castlerea	230	●	—	—	—
St Patrick's	197	●	●	●	—
Arbour Hill	138	—	—	—	—
Portlaoise	117	●	●	●	—
Dóchas Centre	92	●	●	●	—
Training Unit	90	●	—	—	—
Loughan House	87	●	—	—	—
Shelton Abbey	55	●	—	—	—

Source: Irish Prison Service

Note: a Treatment services in these prisons are consultant-led. In other prisons, treatment is overseen by GPs.

16 See National Advisory Committee on Drugs, ***Research Outcome Study in Ireland – 12-month Outcomes***, March 2006 (page xv).

6.4 Addiction counselling services are available in all prisons except Arbour Hill, which is not used to accommodate prisoners requiring treatment for drug misuse. Methadone maintenance and detoxification are available in eight prisons, which together accommodate 74% of the prison population.

6.5 Although Castlerea is a committal prison, it does not have a methadone maintenance programme. Prisoners who are committed to Castlerea and wish to access a methadone programme must be transferred to a prison that has a programme.

6.6 A rehabilitation programme is provided only in Mountjoy prison, but applications for admission to the programme in the Mountjoy unit are open to prisoners in any prison.

6.7 The Prison Service estimates that the cost of drug treatment in prisons in 2007 was €3.3 million. The estimated cost for 2008 is €4.5 million.

Assessment and Care Planning

6.8 On committal to prison, all prisoners undergo a medical assessment, which is conducted by a Prison Service nurse. As part of the assessment, prisoners are asked to declare if they have misused drugs and to outline any previous drug treatment received. Physical evidence of current drug use is also noted e.g. puncture wounds, skin abscesses, etc. If prisoners report that they are current users of heroin, urinalysis is conducted to confirm the use.

6.9 Mandatory drug testing currently takes place in some prisons. The Prison Service plans to extend the mandatory testing regime to all prisons, including testing of all prisoners on committal and prior to their release. This will facilitate the gathering of information on drug misuse trends among prisoners.

6.10 Prisoners presenting with an addiction problem are assessed by the prison GP, who prescribes the treatment to be provided during the period of detention.[17] This takes account of the current treatment status of the individual e.g. if already enrolled on a methadone treatment programme in the community.

6.11 The Prison Service stated that continuity of care into the community is a priority objective and a key element of sentence management in the prisons. Community and voluntary groups in Dublin have been funded to provide seven community/prison link workers. These aim to assist prisoners, including those with drug misuse problems, with reintegration into their families and communities and with accessing the services they may need, including drug treatment, housing, training courses, etc. Similar services are provided in Limerick.

6.12 In the Dutch and Scottish prison systems, the relevant community-based care managers are contacted by the prison services when a misuser is committed to prison and prior to release. This allows each misuser's care plan to be continued or adapted as they move between the community and the prison system.

6.13 Currently, the details of each prisoner's medical assessment, including drug misuse history, are recorded on paper files and, where available, on the computer-based Prison Medical Record System (PMRS) which was first introduced in 2005. The PMRS is intended to allow paper-based record-keeping to be discontinued and to facilitate the compilation of better and more timely data about the provision of drug treatment in prisons.

17 Where consultant-led addiction specialist services are provided, decisions regarding treatment initiation and feasibility are taken under the supervision and guidance of the consultant.

6.14 The PMRS was due to be fully implemented in all prisons by the end of 2007. Most prison health care staff now operate the system.

6.15 The Prison Service provides data to the Central Treatment List about those prisoners receiving methadone, as required by legislation. Up to now, Prison Service staff have not completed NDTRS forms as part of the assessment process. This has left a gap in the collection of data on drug treatment provision. Training in NDTRS procedures is now being given to personnel involved in providing drug addiction treatment in prisons.[18]

Addiction Counselling

6.16 Up to 2007, a limited addiction counselling service was provided in each prison by the Probation Service, delivered either by its own professional staff or by funding community and voluntary groups to provide a service. In addition, drug awareness courses were devised by the Probation Service and Prison Service education staff with the assistance and support of the Prison Psychology Service and HSE counsellors. These courses have been delivered on an ad-hoc basis in prisons in recent years, as resources and staffing have allowed.

6.17 Prior to the establishment of the HSE, the Eastern Regional Health Authority agreed to provide addiction counselling services in prisons in the Dublin region. Funding for the Authority was increased by €300,000 in 2002 to cover the costs of such a service. However, the service was not delivered in 2002 or subsequently by the HSE.

6.18 In 2007, the Prison Service entered into a contract with Merchants Quay Ireland, a community and voluntary sector agency, for the provision of a national addiction counselling service in prisons. Ultimately, the service will provide 24 addiction counsellors in prisons across the State, depending on the demand for service. The annual cost of the service is projected to be €1.2 million. The Prison Service has stated that, by September 2008, addiction counsellors were operating under the contract in all prisons, except Arbour Hill.

6.19 Long-standing local arrangements for the provision of some addiction counselling in Cork and Limerick Prisons are being reviewed in light of the introduction of the Merchants Quay Ireland service.

Methadone Maintenance

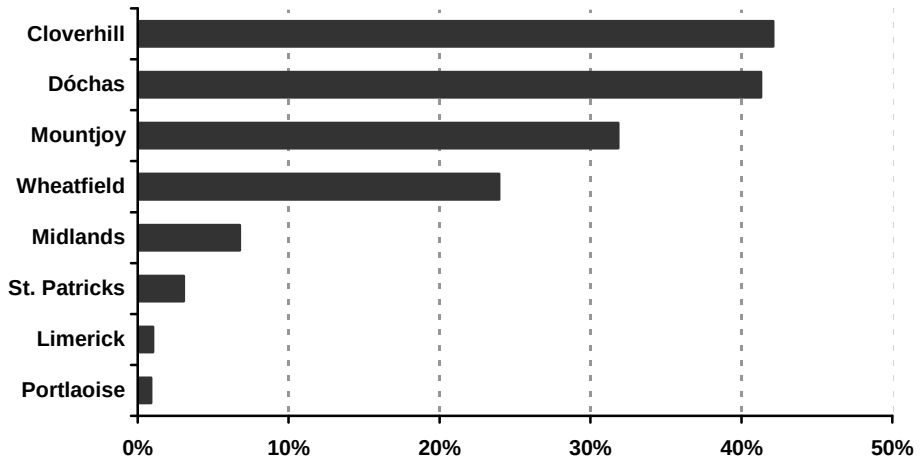
6.20 To gain access to a prison methadone programme, misusers must have a place guaranteed on a community methadone programme on their release. The reason for this policy is that if someone is started on methadone treatment in prison but cannot continue that treatment on release, their lowered tolerance for heroin may increase the risk of an overdose.

6.21 If a misuser is on a methadone maintenance regime in the community at the time of committal, he/she will usually expect to be able to resume the treatment on release. Where the misuser has not been receiving treatment, Prison Service medical staff seek a commitment to provide a post-release place for the prisoner, through liaison with HSE service providers in the area of the prisoner's place of residence. No special priority is given to prisoners in the allocation of community-based treatment places. This avoids any incentive for drug misusers to commit crime as a means of circumventing waiting lists.

6.22 At the end of 2007, 500 prisoners were receiving methadone maintenance treatment in prisons.

18 NDTRS receives a small number of returns from counsellors who provide treatment in prisons.

Figure 6.2 Percentage of the prisoner population on a methadone programme[a], by prison, 2007



Source: Irish Prison Service

Note a: Prisoner population data is average daily number in custody in 2007. The numbers on methadone refer to those on a programme in the prison system on 31 December 2007.

6.23 Between 12% and 15% of those committed to prison over the period 2003 to 2007 were subsequently admitted to methadone maintenance treatment. This was a significant increase relative to 2001, when 8% of those committed to prison were given methadone treatment. The increase reflects both greater provision of methadone treatment in prisons and the higher incidence of pre-committal methadone treatment in the community.

6.24 There is great variation between prisons in the proportion of the prison population receiving methadone maintenance treatment (see Figure 6.2). At end 2007, the number of prisoners on methadone in Cloverhill Prison was equivalent to 42% of the average daily population of the prison. This reflects the use of Cloverhill as a remand prison. In the Dóchas Centre for women 41% of the prison population were receiving methadone maintenance treatment and 32% in Mountjoy Prison.

6.25 Waiting times for access to methadone treatment are not formally monitored by the Prison Service. However, it has stated that in most prisons, prisoners who are prescribed methadone treatment do not usually have to wait to commence treatment.

Detoxification

6.26 If a problem opiate user in prison cannot be guaranteed a place on a community-based methadone programme following release, he/she will be given a short methadone-based detoxification programme. This involves a progressive reduction in the methadone dose over a relatively short period, until methadone is withdrawn completely. The duration of the detoxification process varies from institution to institution, but is typically of 16 or 21 days duration.

6.27 The Prison Service does not routinely compile or report data on how many misusers undergo this programme, or the number for whom a community-based place cannot be found.

6.28 The Prison Service has stated that it proposes to improve the collation of information with regard to the number of prisoners who undergo this programme.

Rehabilitation

6.29 The Prison Service provides a two-phase Drug Programme for heroin and opiate misusers at Mountjoy Prison. The programme was originally developed by the Probation Service, with the support of the Prison Service and community addiction groups in 1996. Since 2007, the programme is managed by the Prison Service. The first phase is a six-week education and learning programme for drug-free prisoners based in the Medical Unit. This seeks to engage selected participants with services, improve self-management and support their drug-free lifestyle in prison and afterwards. Misusers in any of the State's prisons that fit the eligibility criteria can apply for a place. On successful completion of the first phase, most prisoners are transferred to the Training Unit (which is run as a drug-free facility) to serve the remainder of their time in custody.

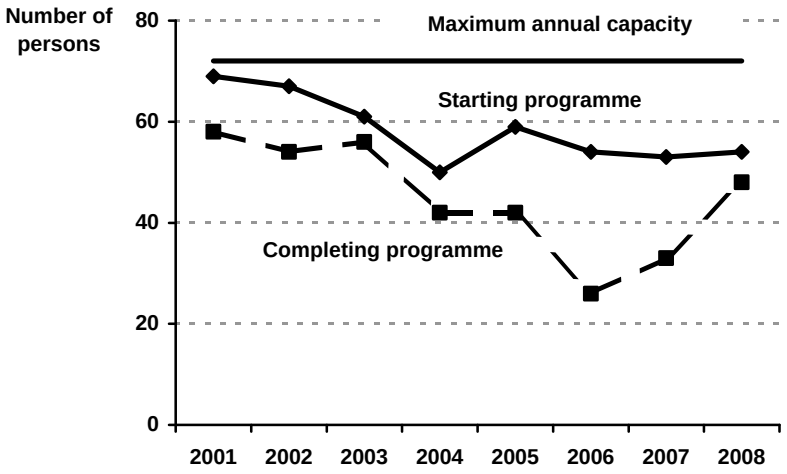
6.30 Nine beds in the Medical Unit are available for participants in the programme. Since each course of treatment is designed to last six weeks (and allowing four weeks unavailability a year to cover staff holidays, refurbishment, etc), the maximum number of misusers that can be treated fully is 72 a year. As Figure 6.3 indicates, 50 to 60 prisoners commenced the programme in the period 2003 to 2008 — between 70% and 85% of the potential maximum throughput of the unit.

6.31 In the period 2001 to 2004, a high percentage (around 85%) of those participating in the programme completed the course. The completion rate fell significantly in the following years. The reported programme completion rate returned to the earlier high level in 2008.

6.32 The Prison Service believes that the increased availability of methadone maintenance treatment in prison reduced both the level of demand for the Drug Programme and the completion rate. Where methadone treatment is available, there is likely to be less of an incentive for misusers to seek rehabilitation treatment. In an effort to maintain high participation rates, Prison Service staff relaxed the programme entry criteria. This may also have contributed to the increased programme drop-out rate in 2006 and 2007.

6.33 A prisoner who remains drug-free in the Training Unit for the rest of his sentence is considered to be a successful outcome of the Drug Programme. There is no target success rate for the programme. While the current status of all participants in each course of treatment is monitored until release, the number of successful cases is not reported.

Figure 6.3 Outcomes of the Mountjoy Prison Drug Programme, 2001 to 2008



Source: Irish Prison Service

Court-Ordered Treatment

6.34 Community-based sanctions are an alternative form of sentencing that is available to judges when they consider that a prison sentence is unsuitable or may be counterproductive. Judges may require offenders to enter addiction treatment as part of a community-based sanction order, if they believe that drug misuse contributed to offences. The threat of a default prison sentence is expected to encourage the offender to comply with the conditions of the order, including the prescribed treatment. Court orders for addiction treatment are normally only made where the appropriate treatment can be made available in a timely way.

Drug Addiction Treatment in Community-based Sanctions

6.35 The Probation Service fulfils a number of roles in relation to cases where a judge is considering imposing a community-based sanction.

- At the judge's request, a probation officer investigates the circumstances of a convicted offender, the kind of community-based sanction that might be suitable in the particular case, the kind of treatment that is required in cases of significant drug misuse, and the availability of the required treatment place. The officer's findings are presented in a report to the Court, to inform the sentencing decision. The judge is not obliged to accept the proposals of the probation officer.
- Where the judge decides to impose a community-based sanction, a probation officer is assigned to supervise its implementation. If the offender does not comply with the specified conditions of the supervision order, the probation officer can return the case to Court. This may result in the offender being committed to prison.
- All probation officers are qualified social workers and some have undergone additional training in addiction counselling. In that capacity, they may sometimes have a continuing involvement in the treatment regimes for individual offenders, in addition to their case supervision function.

The proportion of offenders subject to supervision orders for whom addiction treatment is ordered is not known. The data collected by the Courts Service and Probation Service do not record which orders include drug treatment conditions.

Access to Treatment

6.36 Most of the treatment availed of by offenders under supervision is provided in the normal community-based services. Offenders are not given priority for access to treatment. The policy of the service providers is that all referrals are dealt with in the sequence they are received, irrespective of the source of the referral.

6.37 At a time when the availability of addiction treatment places was more limited, the Probation Service got involved in the planning and funding of special drug treatment services for offenders. This included direct funding of services that were availed of mainly by offenders, or block-booking of places in community-based services for access by offenders. In 2007, the Probation Service provided €2.7 million in funding for 21 voluntary and community-based bodies for such programmes.

6.38 The Probation Service has stated that it is currently reviewing its arrangements for the funding of drug treatment places in the light of the HSE addiction service developments, improved general access to addiction services and consideration of the most appropriate role for the Service in addressing these issues as part of its work. The Probation Service recognises that public funding and support to addiction services in the community should be co-ordinated and integrated as far as possible.

Monitoring Court-Ordered Treatment

6.39 The Probation Service does not formally monitor the length of time referred offenders are waiting for treatment, or the number of offenders for whom a treatment place is not available in time to facilitate a community-based sanction. Without this information, it is difficult to determine if a lack of access to treatment and rehabilitation places is limiting the scope for the Courts to exercise their discretion in applying community-based sanctions in cases where that is considered most appropriate.

6.40 The Probation Service also lacks a system for formally monitoring the outcomes of Court-ordered treatment in cases it supervises e.g. proportion of cases returned to Court because of relapse into drug misuse, proportion of cases completing the prescribed treatment, etc. Such information would help the Probation Service in recommending the most suitable treatment options for individual cases.

6.41 The Department of Justice, Equality and Law Reform has stated that it is developing a data strategy for the Probation Service. A statistician has been seconded from the Central Statistics Office to the Probation Service to work on the development and enhancement of case management data.

The Dublin Drug Treatment Court

6.42 Special drug courts began to be established in the US around 1989/1990. Based on the reported success of the early courts, a similar approach has subsequently been adopted in many parts of the US and in other jurisdictions.

6.43 A Drug Treatment Court (DTC) was established in Dublin in January 2001, on a 12-month pilot basis. The Court was established in the north inner city area, an area with both a high incidence of drug-related offending and relatively well-developed addiction treatment services.

Operation of the Court

6.44 The DTC is held before a District Court judge, who is assigned to the role on a part-time basis. The judge is assisted by a team comprising a probation officer, a nurse and an education co-ordinator on a full-time basis, and a Courts Service co-ordinator and two Gardaí on a part-time basis. All the team members are drawn from the existing resources of the bodies participating in the initiative.

6.45 Court sittings are held one day a week, with pre-court meetings of the judge and the team to discuss cases and to share information. Decisions in each case are made by the judge during the court sittings, which are attended by the team members and by the relevant offender.

6.46 Admission to the Court programme depends on an offender being both eligible and suitable for the programme. To be eligible, they must have been resident for six months or more in the target catchment area (currently Dublin 1 and Dublin 7 postcode areas). Suitability criteria include the offender not having a history of violent crime, already attending a registered clinic and willingness to participate in the programme.

6.47 An individual plan is developed for each participant found suitable for admission to the programme. The duration of the plan is typically 18-24 months. Each participant is required to appear before the Court on a regular basis, to attend prescribed meetings with the DTC team members and to undergo regular drug testing (e.g. urinalysis). Participants must be in gainful employment or engage in appropriate educational or occupational training courses. They must also address their offending behaviour and have no new offences.

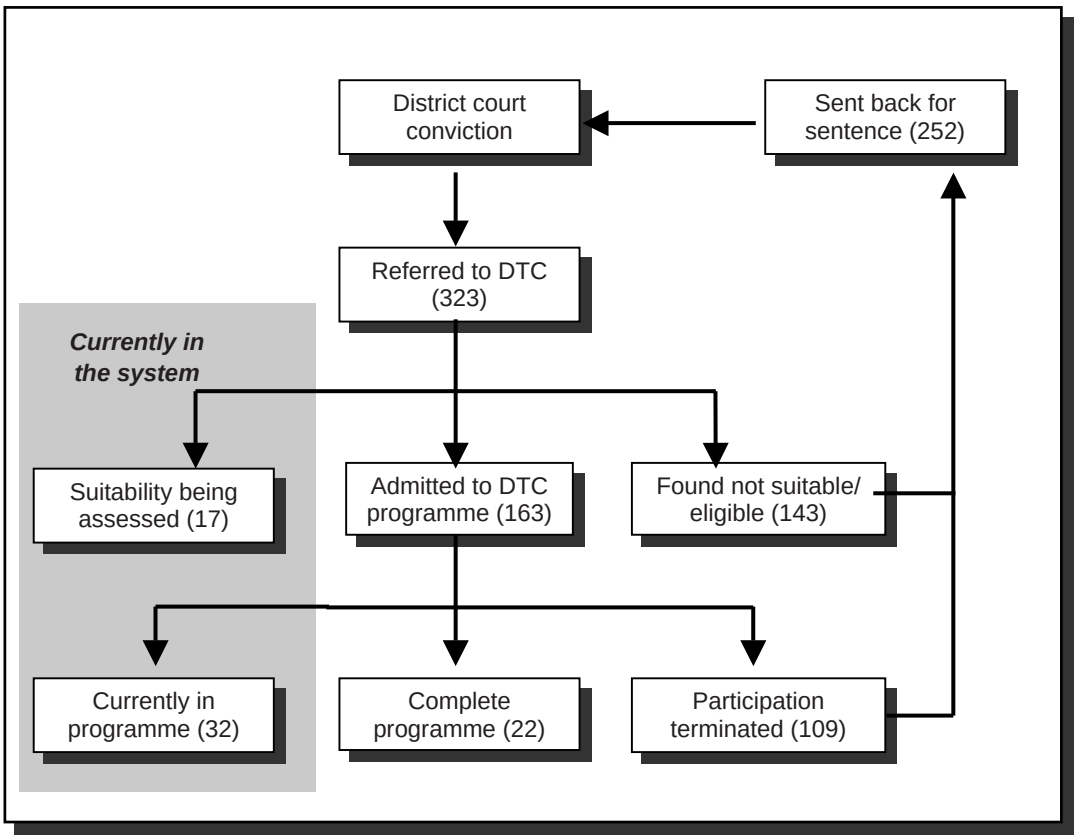
6.48 A system of penalties and rewards is used to encourage adherence to the programme, but if there is persistent failure in this, the judge may terminate the individual's participation in the programme. Participants are considered to have successfully completed the programme when they achieve a stable situation in relation to management of their addiction and their personal circumstances. While participants may remain on methadone treatment, they must be free of any unprescribed drugs, including cannabis, to graduate from the programme.

Programme Throughput

6.49 Figure 6.4 indicates the level of throughput of cases from the establishment of the DTC on a pilot basis in January 2001 up to the end of July 2008.

6.50 District Court judges referred a total of 323 cases to the DTC — an average of 43 referrals per year. At end July 2008, 17 cases were still in the process of being assessed for suitability for the programme. On average, the DTC takes around eight weeks to assess referrals.

Figure 6.4 Throughput and outcomes of Dublin Drug Treatment Court, Jan 2001 – July 2008



6.51 Following assessment, around 53% of cases referred to the Drug Treatment Court were found to be eligible and suitable for admission. The 47% of offenders found to be unsuitable or not eligible for the programme were referred back to the relevant courts for sentencing.

6.52 When the DTC was established, it was envisaged that it would handle around 100 cases during the 12-month pilot period. In practice, 37 offenders were admitted to the programme during the pilot. From January 2001 to July 2008, an average of 22 offenders a year were admitted to the programme i.e. just over one fifth of the initial annual target.

6.53 A review was conducted in 2005 to determine the reasons for the low number of persons being dealt with in the DTC. The findings of the review were as follows

- The review proposed an extension of the catchment area to include the entire Dublin Metropolitan District.
- The review found that a certain percentage of eligible clients decline to participate in the programme as they regard the regime to be too severe.
- The review noted that there was a need to better inform the members of the judiciary, legal profession and members of the wider community about the work of the DTC.

6.54 Excluding those still active in the programme, around 83% of those admitted subsequently had their participation terminated by the Court. Just 17% of programme participants (22 individuals) completed the full programme to the satisfaction of the court.

6.55 The programme completion rate for the DTC is significantly lower than is the case elsewhere. For example, evaluations of 16 drug courts in the US found programme completion rates that ranged from 27% to 66%.[19] Among the factors identified as influencing the wide variation in the completion rates of the US programmes were

- the motivation of participants to complete the course, including their perceptions of the prison sentences they faced if dropped from the programme
- the availability and effectiveness of treatment and supports for participants
- differences in programme completion requirements
- varying attitudes of the judges to infringements of the conditions

6.56 The Courts Service has pointed out that the high programme completion rates in some US drug courts reflects significant differences in the objectives, operations and resourcing of the courts, compared to the Dublin Court. A key difference is that many US drug courts tolerate participants using some unprescribed drugs (e.g. cannabis) at the end of the programme. Some US courts also have their own dedicated treatment facilities, and participants may volunteer to be involved in the programme (including paying fees for treatment). The Courts Service stated that by comparison, most participants in the DTC programme come from a culture of unemployment and drug abuse and that there may be delays in accessing health assessments and services

6.57 The Department of Justice, Equality and Law Reform has stated that it is currently examining the operation of the DTC to determine the reasons behind the relatively low numbers of persons being dealt with in the DTC. The review will consider measures to increase throughput including whether the criteria for qualification for the programme should be revised and will determine whether a further expansion of the DTC is desirable having regard to the results to date.

19 US Government Accountability Office, **Adult Drug Courts**, February 2005, GAO-05-219

Evaluation of Effectiveness

6.58 The goals of the Drug Court programme include

- reducing drug usage among participants
- reducing recidivism
- reducing social dysfunction
- reducing the overall cost to the State of dealing with the individual.

6.59 The Courts Service commissioned an evaluation of the DTC's first year of operation (i.e. January 2001 to January 2002).[20] This looked at the effectiveness of the programme in terms of its impact on the behaviour and lives of participants, and at its cost-effectiveness. The low number of participants on the pilot programme (a total of 37) and the short time period covered by the evaluation limited the extent to which conclusions could be drawn. Nevertheless, the evaluation found indications that the DTC was effective. For example

- The majority of participants in the programme had previous convictions and presented a high risk of re-conviction. Some continued offending while on the programme but the average rate of arrest and charging declined. In most cases, the longer the individual remained within the programme, the greater the apparent reduction in re-offending.
- The percentage of urinalysis tests of programme participants found to be negative for opiates increased from 42% during the first three months of the programme to 82% for the last three months. At the end of the evaluation period, 11 of the 37 participants (30%) were clean of all illicit drugs
- The evaluation also considered the impact of the Court on the cost of dealing with offenders with a drug problem over the first year of its operation. It did not find that the operation of the Court had resulted in significant cost savings for the justice system. This was attributed to the relatively low numbers involved in the programme, resulting in underutilisation of the team. Another factor keeping costs high was the amount of custody time amassed by participants. For a number of participants, this arose because of the revocation of bail in circumstances where suitable short-term residential accommodation was not available. In these cases prison was the only option to stabilise the behaviour of participants who could not be managed in a community setting

These findings are similar to the findings of evaluations of drugs courts in other jurisdictions (see Figure 6.5

6.60 The evaluation of the pilot DTC did not compare the longer-term effectiveness of the Court programme with that of court-ordered supervision in other district court areas, or of custodial sentences. No further evaluations of the effectiveness of the Court have been carried out since 2002.

20 Courts Service, **Final Evaluation of the Pilot Drug Court**, Farrell Grant Sparks Consulting and Dr Michael Farrell, October 2002.

Figure 6.5 Evaluations of the Effectiveness of Drugs Courts in the US and Australia

Many evaluations have been carried out of the effectiveness of drugs courts in the US. A systematic review of evaluations by the US Government Accountability Office (GAO) concluded that care must be taken in making comparisons of the effectiveness of drugs courts because not all evaluations address the same issues, and not all use consistent methodologies.

Surveying comparable evaluations of US adult drug court programmes, the GAO found that

- Most of the programmes led to reductions in re-offending during the drug court programme.
- In most of the evaluations that tracked post-programme impacts, there was evidence also of a reduction in re-offending for some time after participants completed the programme.
- The impact of drug court programmes on participants' substance use showed mixed results. For example, urinalysis test results generally showed significant reductions in drug use during participation in the programme, but participants themselves reported no significant reductions in drug misuse.
- The running of most drug court programmes were found to cost more per participant than the amount spent by the justice system on dealing with comparable offenders not on the programme. However, drug treatment court programmes were found to yield positive net social benefits, primarily because the reductions in re-offending reduced judicial system costs and avoided costs to potential victims.

An overview of evaluations of the impacts of drug courts operating in Australia had similar findings. However, the report pointed out that most of the evaluations related to the initial periods of operation of the courts, during which their operational processes and policies were still being developed. It also emphasised the difficulties of carrying out methodologically sound evaluations of drug courts.

Source: US Government Accountability Office, **Adult Drug Courts**, February 2005, GAO-05-219

Wundersitz, Joy, **Criminal justice responses to drug and drug-related offending: are they working?** Australian Institute of Criminology, Technical Background Paper No. 25, 2007

Expansion of Drug Treatment Court

6.61 In early 2006, the DTC was put on a permanent footing. The Courts Service announced that its remit would be expanded in a staged way to cover the entire city of Dublin. However, the planned expansion has not occurred, and the DTC continues to operate on much the same basis as during the pilot exercise.

6.62 The Courts Service has stated that the President and Judges of the District Court and the Court Service itself are keen to extend the catchment area of the DTC to cover all of Dublin city. They consider that the DTC provides an excellent service for those who opt for it and participate fully in it. However, the DTC relies on the availability of support services from the treatment centres, the Probation Service and An Garda Síochána. The Courts Service has stated that the planned expansion has not occurred because the other agencies, and in particular the HSE, have not been in a position to make available the necessary services and resources.

Conclusions

6.63 Because of the high proportion of those in prison who have drug use problems, the Prison Service is a significant provider of drug addiction treatment.

Continuity of care when patients move between the community and prison needs to be improved. In order to achieve this, care planning and key working in the community needs to be developed and the service provided recorded through the NDTRS.

6.64 At any one time, around 500 prisoners are in receipt of methadone maintenance. At full capacity, the Medical Unit in Mountjoy could provide drug-free rehabilitation programmes for around 70 prisoners a year. Participation in the rehabilitation programme, and the rate of successful completion of the programme have varied. This may reflect the level of availability of methadone maintenance treatment.

The information about the incidence of drug use among prisoners needs to be improved. The Prison Service should develop its own internal case management and reporting system in order to provide information on the progression of those treated in prison and their treatment outcomes. In doing so, it should adhere to the NDTRS reporting protocol.

6.65 The Probation Service refers a significant number of individuals for assessment of their suitability for treatment for problem drug use. However, its case management systems do not allow it to readily identify the extent of the treatment services it seeks on behalf of its clients, or of the length of time they have to wait for treatment.

While it is acknowledged that the Probation Service is taking steps to improve and enhance its case management data, there is scope to manage the referral process more effectively. It should, in particular, monitor the length of time that offenders wait for assessment or treatment and the number of offenders that are unable to access required treatment places. The Service should also monitor the outcomes of court-ordered treatment for the cases it supervises. Because treatment service providers do not give priority to those referred by the Courts over those referred from other sources, the experience of the Probation Service could provide a useful perspective on the availability and timeliness of drug treatment generally.

6.66 An evaluation in 2002 of the first year of operation of the DTC found some evidence that it was an effective approach. However, the DTC has a low throughput of cases, and a small proportion of cases that achieve the objective of abstaining from all illegal drugs. The Courts Service has proposed its expansion, but the necessary commitments have not yet been made by other agencies to give effect to this expansion.

The effectiveness of the DTC needs to be evaluated, now that a significant period of operation has elapsed. The evaluation should compare the cost and effectiveness of the Court with the cost and effectiveness of orders made by other courts that include treatment of those sentenced to community-based orders. This should help identify the most appropriate way to develop the service in the future.

7 Social Support and Reintegration

7.1 Drug use problems are often associated with significant difficulties in the personal lives of the users and/or of their families. These may include breakdown in family life and personal relationships, money problems, poor educational achievement, and loss of employment or of the home. Where these difficulties arise, other forms of social support and reintegration interventions may be required if treatment of drug addiction is to be effective in the long-term.

7.2 This chapter looks at the provision of support for persons seeking, receiving or following treatment for addiction in the key areas of

- accommodation
- education, training and employment
- childcare.

Accommodation

7.3 There is a high incidence of drug misuse (both alcohol and illicit drugs) among homeless people i.e. those living on the streets or in emergency accommodation. An investigation of drug misuse among a sample of 355 homeless people in Irish cities in 2004 found that over half were current users of illicit drugs.[21] (This compares to just under 3% of the population generally who report they currently use illicit drugs.[22]) The investigation also found that homeless people with drug and alcohol problems had greater difficulties in accessing accommodation than those who did not have such problems, and that many drug treatment service providers did not have specific policies designed to meet the particular needs of homeless drug users.

7.4 The data show that almost nine out of ten persons who were assessed for drug addiction treatment live in stable accommodation situations. As Figure 7.1 indicates, around 7% to 8% of those entering treatment each year are recorded as being homeless, and a further 3% to 4% are in some other form of unstable accommodation e.g. staying temporarily with friends or family members without paying rent. A small percentage of those treated live in institutions.

7.5 Homelessness or an unstable accommodation situation does not preclude an individual from receiving treatment for problem drug use. However, since the data relate only to persons entering (or re-entering) drug addiction treatment, they do not provide an indication of the number of individuals for whom the lack of stable accommodation may hinder their access to required treatment, or of the extent to which ongoing or recurring problems with accommodation may be associated with dropping out from treatment or other poor treatment outcomes.

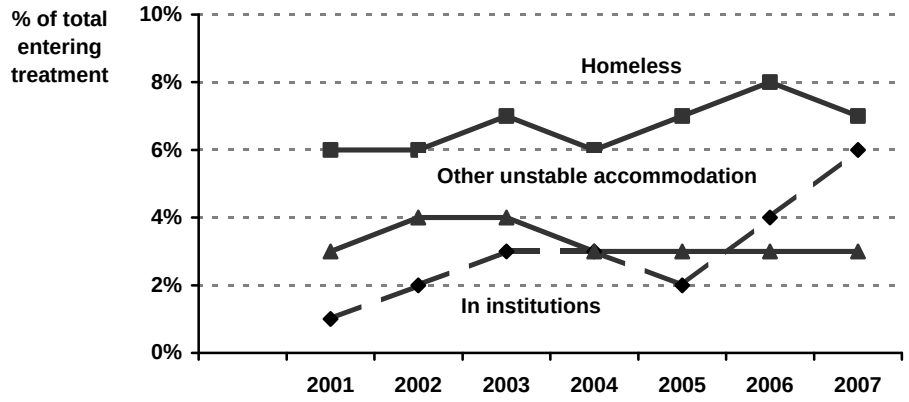
7.6 Responsibility for dealing with homelessness among drug users is shared between a number of agencies. The local authorities are responsible in the first instance for the provision of accommodation for the homeless. The HSE is responsible for the provision of care and welfare services required to help maintain and support homeless people in emergency or transition accommodation, and (where suitable) subsequently to move on to independent living in permanent accommodation.

---

21 Drug Use Amongst the Homeless Population, NACD, 2005

22 Data on prevalence of drug use, NACD, Bulletin 1, 2006/2007

Figure 7.1 Percentage of persons entering drug addiction treatment, and not in stable accommodation, 2001 to 2007[a]



Source: National Drug Treatment Reporting System.
Note: a Excludes cases where status is unknown.

7.7 The Department of the Environment, Heritage and Local Government (DEHLG) and the HSE jointly fund the non-statutory Homeless Agency to plan, manage and co-ordinate services for the homeless in the Dublin area, and to implement agreed action plans that aim to eliminate homelessness in Dublin by 2010. The Homeless Agency operates through a partnership structure, bringing together the statutory and voluntary agencies involved in planning, funding and delivering services to homeless people.

7.8 The HSE has stated that, since 2000, many local authorities have established adult homeless forums, in conjunction with key partners (including the HSE itself). These forums attempt to identify and deal with the complex care, social and accommodation needs of the homeless in their individual areas.

7.9 Both the DEHLG and the HSE recognise that homeless drug and alcohol misusers have specific needs that differentiate them from other homeless persons, and try to meet those needs in the way they provide accommodation for homeless people e.g. wet hostels to cater for active alcohol and drug users. There are two wet hostels for alcohol and one that caters for drugs and alcohol. Much of the special accommodation is provided by funding community and voluntary groups to deliver the required services.

7.10 Multi-disciplinary health teams for homeless people (including homeless drug users) have been established in Dublin, Cork, Limerick, Waterford and Kerry. The team members have a variety of skills including addiction, nursing, and psychiatry skills which enables clients with multiple care issues to access required services. For example, the Safetynet service in Dublin provides a GP, nursing, vaccination and counselling service to homeless people. It also provides a methadone maintenance service in a large emergency hostel for problematic drug users who, for a variety of reasons, are not accessing other treatment centres. Another example of an innovative approach is the partnership between Dublin Simon, HSE Dublin North Addiction Service and Safetynet, which provides an out-of-hours outreach harm reduction service to homeless drug users.

Accommodation of Recovering Misusers

7.11 Homeless misusers in receipt of treatment, or who have completed treatment and want to remain drug-free should ideally be accommodated separately from those who are still misusing drugs. Being required to share accommodation with misusers may put additional pressure on them to relapse.

7.12 Some of the residential addiction-treatment facilities have step-down (or half-way) housing linked to their services. This potentially avoids recovering misusers immediately encountering accommodation difficulties, either due to homelessness, a drug misuse environment in a former home, or targeting by drug dealers.

7.13 The HSE funds a total of 29 step-down accommodation places for persons recovering from drug addiction. A further 89 step-down places are available for persons recovering from alcohol and/or drug addiction, but the majority of the service users admitted to those places present with alcohol addiction.

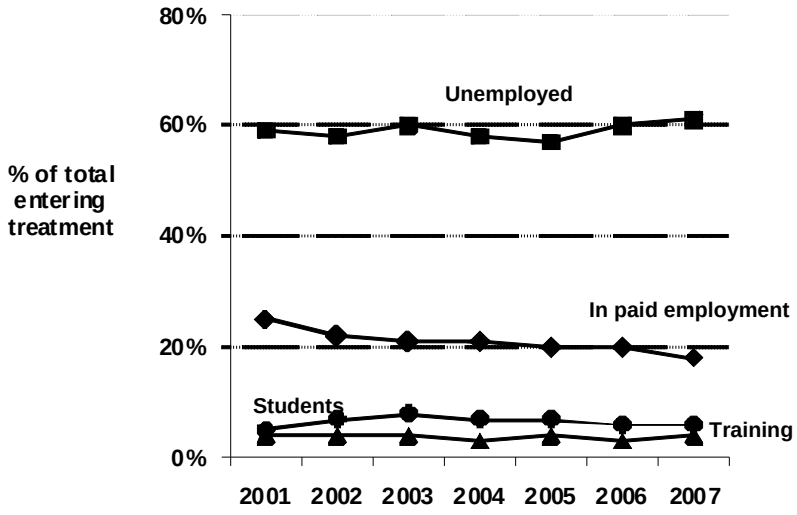
7.14 Those accessing step-down accommodation usually have the option to stay for at least six months. Ultimately, the aim is for residents to graduate to independent living in suitable stable accommodation. The percentage of residents who achieve that target is not known.

7.15 Three of the step-down accommodation projects were visited as part of this examination. In each case, the managers reported that the demand for accommodation places exceeded the number of places available. However, there is no national monitoring of waiting times for those undergoing rehabilitation to access transitional or long-term accommodation.

Education, Training and Employment

7.16 Consistently, around 60% of those commencing drug addiction treatment report that they are unemployed. Around 20% report that they are currently in paid employment, with a further 4% participating in FÁS schemes or other training. Around 6% are students. See Figure 7.2.

Figure 7.2 Principal economic status of persons entering drug addiction treatment, 2001 to 2007[a]



Source: National Drug Treatment Reporting System.
Note: a Excludes cases who were housewives, retired, disabled and where employment status was unknown.

7.17 Around three out of four of those entering treatment are early school leavers, having left full time education at age 16 or earlier. This is three times the level for the population in general in the age range 15 to 64.

7.18 In most cases where education and training interventions are being made in support of unemployed persons, the primary focus is on improving their skills and preparing them for employment. In contrast, when dealing with unemployed drug misusers, the first requirement is often for stabilisation of the situation of the individual in terms of drug misuse and in ensuring that basic needs (such as housing and health care) are met. Once this is achieved, there may be potential through education and training to assist in the personal development of clients, including in the development of basic education and personal coping skills. In the longer term, there may be potential to deliver training and help develop the potential of the individual to avail of job opportunities.

7.19 Drug rehabilitation programmes usually include elements aimed at the development of personal coping skills. Depending on the prior education level and employment experience of the individual concerned, further education and training in basic life skills may be required just to prepare a recovering addict for formal work training, and to motivate them to seek employment.

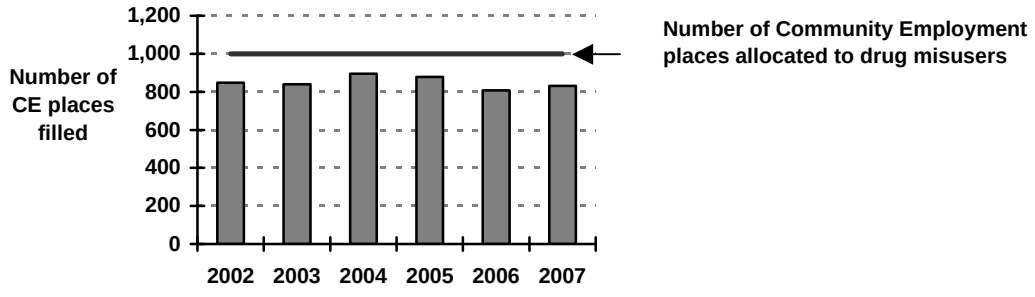
Community Employment Schemes

7.20 Community Employment operates through local projects sponsored by community and voluntary groups. The groups submit proposals to FÁS, outlining the objectives for the project, the geographical area to be served and the means of operating. If the proposal fits in with FÁS objectives (e.g. target number of places in a geographic area; type of programme, etc), it may grant funding for the project. The project sponsors are required to sign a service agreement that outlines the work programme and the target outcomes. Projects are monitored annually to ensure agreed training and education modules are completed.

7.21 In 1997, FÁS allocated 1,000 places nationally in its Community Employment programme to support projects that aim to provide training for drug misusers.

7.22 The full allocation of 1,000 Community Employment places for drug misusers has not been utilised (see Figure 7.3). The maximum utilisation of the allocation, was around 90% in 2004. In 2007, this fell to 83% utilisation.[23]

Figure 7.3 Number of Community Employment places allocated and filled, 2002 to 2007



Source: FÁS

23 The unutilised places were available to be used by other projects or by other scheme applicants.

7.23 The underutilisation of the places allocated for drug misusers occurred at a time when the numbers in treatment was increasing significantly. FÁS has stated that it is dependent on the referral of participants from other organisations, and that it has always placed those referred to them under this initiative. FÁS also pointed out that other drug users may be participating in Community Employment Schemes without declaring that they are in treatment.

7.24 In 2001, the National Drugs Strategy included a target of increasing the number of training places to 1,300 by the end of 2004. The number of places was not increased since the 1,000 available places were not being fully utilised.

7.25 The primary objective of Community Employment is to prepare participants for entry into the active labour force. The main focus of the Community Employment schemes for those with drug use problems is on acting as a support framework through which drug rehabilitation interventions can be delivered. In that context, progression of a participant to an education course or to another FÁS training scheme would represent a successful outcome, and might be more achievable in many cases than entry into the workforce.

7.26 FÁS commissioned an evaluation of the Community Employment schemes for drug users which was reported on in 2004.[24] The key findings of the evaluation were

- Participants in Community Employment schemes surveyed as part of the evaluation generally found the schemes beneficial in meeting their therapeutic and rehabilitative needs.
- There were difficulties in balancing the rehabilitative and employment-oriented dimensions of the schemes to meet individual needs.
- While international evidence showed that the focus on employment in such schemes is beneficial, the timing of participation in a scheme during the rehabilitation process has a major impact on the likelihood of a successful outcome.
- Progression to employment was not seen as a realistic option for many participants.

Other Training Initiatives

7.27 The 2007 Report of the Working Group recommended the development of a pre-Community Employment stabilisation initiative, focused on preparing selected individuals for participation in Community Employment schemes. A maximum of three months preparation for an individual is envisaged. The report recommended that the HSE would take the lead in the provision of the programme, supported by FÁS, the relevant Vocational Educational Committees and Community Employment scheme organisers.

7.28 FÁS has stated that it has developed a pre-Community Employment stabilisation initiative in Cork and a 'Local Training Initiative' in the South East to act as a feeder to Community Employment.

7.29 In conjunction with the Vocational Education Committees, FÁS has also developed a 'Return to Education' initiative within mainstream Community Employment which is available on a national basis, providing literacy, numeracy and personal skills development. It has also introduced 'Core Skills' which is a personal and career development initiative for disadvantaged learners in Community Employment schemes.

---

24 Review of the Drugs Task Force Project Activity for FÁS Community Employment Participants, Alan Bruce, 2004

7.30 FÁS now draws up Individual Learner Plans for persons registering with them. This approach aims to assess service users on an individual basis and provide a plan tailored for their particular needs. This potentially fits well with the individual care plans that might be developed by key workers, to help those in treatment to access structured and suitable education and training interventions at the appropriate time.

Childcare Support

7.31 Approximately 15%[25] of those entering treatment for drug addiction in 2007 were living with dependent children. For others, a lack of access to childcare can present a barrier to access to treatment (on a residential or out-patient basis) and/or to education and training.

7.32 The National Drugs Strategy recommended that the HSE should "… consider how best to integrate childcare facilities with treatment and rehabilitation centres, so that childcare needs do not interfere with the uptake of treatment and rehabilitation services." However, no firm policy on childcare support has been set.

7.33 In practice, the current provision of childcare for drug misusers is limited. For example

- The HSE do not provide childcare facilities in most addiction service premises. This can force parents to attend their treatment appointments with their children. This, in turn, may limit the issues which can be addressed with the patient during the appointments, and cause added strain on all involved.
- Community and voluntary groups provide limited childcare facilities in a number of areas. Some groups also provide 'breakfast and homework' clubs for the children of misusers.
- Very few special Community Employment schemes provide childcare for participants.

7.34 The 2007 Report of the Working Group reiterated the recommendation that the HSE, together with the Office of the Minister for Children, should determine how to integrate childcare services with treatment and rehabilitation. It also recommended that

- an audit of gaps in existing childcare provision for children of problem drug users should be undertaken
- childcare services for children of problem drug users should adopt an approach focused on the development needs of the children
- parenting programmes for problem drug users should be developed and implemented.

25 National Drug Treatment Reporting System, 2007

Conclusions

7.35 A range of additional supports is often required if effective treatment of addiction problems is to be achieved. The nature and level of support required by individuals varies and may also change as treatment progresses, and timely provision of supports can influence the likelihood of successful treatment outcomes.

Where care planning and key working systems are being developed in the context of treatment and rehabilitation for drug use, they should include within their scope, consideration of the wider social supports required by the individuals concerned. Protocols developed for interagency work should cover referral and reporting to social support providers e.g. local authority housing departments and FÁS, etc.

Waiting times for accessing required social support services should be formally monitored and reported on.

7.36 A significant proportion of homeless people have drug (and/or alcohol) use problems. Homelessness does not preclude someone from accessing treatment for drug use, but it tends to act as a deterrent to beginning or continuing treatment.

Comprehensive care planning would help to identify the extent to which those receiving treatment require assistance with accommodation.

7.37 Many of those receiving treatment for problem drug use are early school leavers, with low educational attainment and a history of unemployment. While mainstream education and training programmes are important elements in the rehabilitation and reintegration process for some, special programmes in the areas of basic education and training — such as the pre-Community Employment stabilisation initiative — are envisaged to ensure that those with the greatest skill and competence deficiencies also have an opportunity to progress.

The effectiveness of special Community Employment schemes for people in drug rehabilitation should be evaluated from time to time.

8 Co-ordination and Monitoring of Strategy

8.1 The National Drugs Strategy sought to ensure effective co-ordination between the many agencies involved in countering drug addiction, including those involved in the provision of drug treatment and rehabilitation services. The main government agencies concerned in providing treatment and rehabilitation services — the HSE, Prison Service, Probation Service and FÁS — have key responsibilities also in other areas, resulting in competition between programmes for the available resources. Heavy reliance in the provision of treatment and rehabilitation services is also placed on a wide variety of community and voluntary agencies, operating at local or national levels.

8.2 This chapter looks at the effectiveness of the arrangements put in place to co-ordinate and monitor the National Drugs Strategy.

Co-ordination Structures

8.3 A common theme identified in the consultation process leading up to the publication of the National Drugs Strategy in 2001 was the need for greater co-ordination within and between the agencies involved in countering drug misuse. In response to those concerns, one of the stated objectives of the National Drugs Strategy was to put in place an efficient and effective implementation framework to co-ordinate activity and service delivery.

National Co-ordination Framework

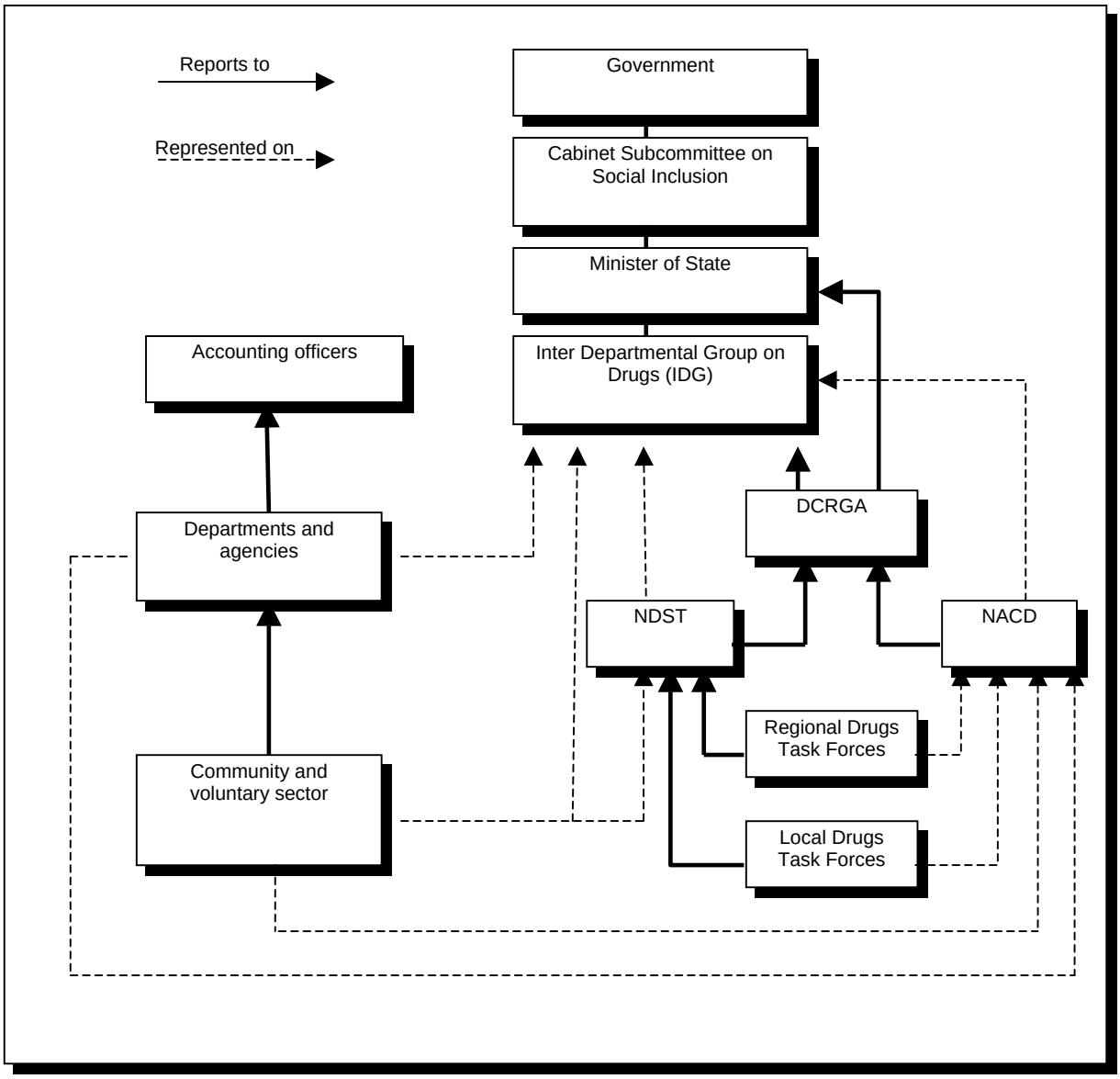
8.4 The main structures and reporting relationships that form the framework for co-ordination and integration of the National Drugs Strategy are outlined in Figure 8.1. The State agencies involved in policy development, service delivery and co-ordination are represented at various levels in the structures. Cross-membership is a feature of the framework e.g. the Chairs of the NDST and NACD are members of the Inter-Departmental Group on Drugs (IDG), and the Director of the NDST is a member of the NACD.

8.5 The IDG has not operated as intended. The mid-term review of the Strategy in 2005 found that agencies had frequently not been represented at the level of seniority envisaged (Assistant Secretary or equivalent). Representation at a lower level resulted in an overlap of membership between the IDG and the NDST, leading to a blurring of the responsibilities of the two bodies. This problem has not been fully resolved to date.

8.6 The mid-term review also found that the IDG did not have representation from all of the agencies that had a role in drug treatment and rehabilitation. It recommended that the HSE, the Department of Social and Family Affairs and the Irish Prison Service should join the Group. While the HSE is now represented, the other agencies are not.

8.7 The co-ordination framework outlined in Figure 8.1 was augmented with a further element in November 2008, as the National Drug Strategy's term was drawing to a close. The HSE established a National Drug Rehabilitation Implementation Committee (NDRIC) to oversee and monitor the implementation of the recommendations on rehabilitation contained in the 2007 Report of the Working Group. The NDRIC is chaired by the HSE and has a professional (rather than administrative/managerial) focus, primarily involving those engaged in rehabilitation.

Figure 8.1 Framework for Co-ordination and Monitoring of the National Drugs Strategy



Drugs Task Forces

8.8 Drugs task forces were established to provide a mechanism to enable local communities to work with State and voluntary agencies in the design and implementation of programmes to address local needs. Their role is to develop and implement drugs strategies for their respective areas and to identify and tackle gaps in services at local level. They also try to co-ordinate all local programmes that address drug awareness, drug use prevention and treatment and rehabilitation. The task forces were developed on the basis of two initiatives

- ***Local drugs task forces*** operate in 13 areas of greater Dublin and in one area in Cork. They were originally established in 1997, in areas where drug misuse and the associated problems were greatest.
- The National Drugs Strategy proposed the establishment of a national network of ten ***regional drugs task forces*** serving regions corresponding with the former health board areas.

8.9 The work of each of the task forces is co-ordinated by a full-time task force co-ordinator employed by the HSE — a total of 24 posts. Co-ordinators for the regional task forces were initially appointed on a part-time basis, but following the mid-term review of the National Drugs Strategy in 2005, those posts were put on a full-time basis. Vacancies in the co-ordinator posts that arise from time to time can impact on the work of the task forces.

8.10 The mid term review identified a need to improve information exchange between the task forces (both local and regional) and the State agencies represented on them. In interviews with participants in task force structures during this examination, there were reports that the lack of authority of some agency representatives on the task forces to make commitments was an obstacle to their smooth operation. This was compounded by a lack of continuity in agency representation at task force meetings.

Evaluation of Drugs Task Forces

8.11 In 2006, the DCRGA commissioned a review of the local drugs task forces.[26] The purpose of the review was to

- establish the outputs, effectiveness and efficiency of the local drugs task force programme
- make recommendations to improve effectiveness and efficiency
- define performance indicators and baselines in order to measure the work of the local drugs task force in the future.

8.12 The evaluation concluded that the local drugs task force programme had been very effective because a large number of measures relevant to the objectives set in the National Drugs Strategy had been implemented to address the drug problem at the local level. There was also evidence of higher levels of trust emerging between local communities and the statutory agencies concerned with drug abuse and this was attributed to the communication and mediation role of the local drugs task forces. While generally endorsing the role of the local drugs task forces, the evaluation also identified a number of areas where there was scope for the efficiency and effectiveness to be enhanced through improved monitoring and evaluation of the individual projects.

8.13 A similar evaluation has not been carried out of the operation of the regional drugs task forces.

Local Projects

8.14 The drugs task forces play a key role in relation to the establishment, funding and oversight of programmes in their respective areas. Where a local (or regional) need for a drugs-related service is identified, local community or voluntary groups are invited to develop an appropriate response and present a project to the relevant task force. If the proposed projects fit in with the task force's strategic plan, and the organisation, governance and reporting arrangements for the project are satisfactory, the task force may recommend the project for consideration by the NDST. If approved in turn by the NDST, DCRGA channels the required funding to the project through a statutory agency. Around 80% of the projects that have been approved for funding on this basis are overseen by the HSE, with most of the remainder overseen by FÁS and the Probation Service.

---

26 Goodbody Economic Consultants, **Expenditure Review of the Local Drugs Task Forces,** 2006

Figure 8.2 Expenditure by DCRGA on Interim funded Task Force Projects, 2007

Project objectives	Sponsoring task force		All interim funded projects
	Local	Regional	
	€m	€m	€m
Treatment and rehabilitation[a]	11.5	4.1	15.6
Other (education, drug prevention, etc.)	8.6	3.0	11.6
All interim funded projects	20.1	7.1	27.2

Source: DCRGA

Note: a Includes all projects where treatment and rehabilitation is the primary project activity, or where they form an element of the project objectives.

8.15 Task force sponsored projects are initially funded on an interim basis. While a project remains on an interim-funding basis, its sponsors are required to report annually about their finances and performance to the relevant task force, which in turn reports to the NDST and DCRGA.

8.16 Figure 8.2 outlines the expenditure by the DCRGA on task force projects funded on a interim basis in 2007. The total funding for projects was just over €27 million. Of this, 57% was provided for projects providing treatment and rehabilitation services, or where treatment and rehabilitation formed a part of the project objectives.

Mainstreaming of Projects

8.17 After a period of operation, interim projects may be evaluated by the NDST, and if considered successful and worthwhile, may be recommended for 'mainstreaming'. At that point, funding and oversight becomes the responsibility of a statutory agency, supervised by a government department other than DCRGA.

8.18 Two rounds of evaluations of local drug task force projects have been conducted to date, to identify projects suitable for mainstreaming. As a result of the first round, conducted in 2001, 119 out of 143 projects evaluated were mainstreamed.

8.19 A second round of evaluations of local drug task force projects was undertaken in 2007/2008. The DCRGA has stated that of the 283 projects evaluated in that round, the majority have been recommended for mainstreaming, some with minor modifications. Only 38 projects (13% of the total) were found not to be suitable for mainstreaming. Of these, 14 are considered to be more suitable to an alternative funding source. The DCRGA considers the small number not suitable for mainstreaming to be indicative of the success of the interim funding model.

8.20 Interim funded projects sponsored by the regional task forces are generally relatively recently established. None of those projects has yet been evaluated for mainstreaming.

8.21 Following the transfer of projects from interim to mainstream funding, it is expected that the drugs task forces will maintain their role in oversight, monitoring and reporting of local projects. This is designed to ensure that projects continue to fit in with local needs and priorities for services.

Monitoring and Evaluation of Drug Strategy Implementation

8.22 The DCRGA, as the lead department, had responsibility for establishing an evaluation, monitoring and reporting framework for the National Drugs Strategy. It was envisaged that this role would be carried out by the IDG, in conjunction with the NDST. The elements of the framework included monitoring of key performance indicators and evaluations of the cost-effectiveness of the various elements of the strategy, with progress being reported in annual reports and in a mid-term evaluation report on the strategy.

Reporting of Performance

8.23 A 'critical implementation path' for the National Drugs Strategy was published in 2004. This reviewed how each of the actions of the strategy was being delivered, and the timeframe for delivery to completion. The steps that needed to be taken in order to complete each action were also set out.

8.24 A formal strategy progress report was published in 2004. Apart from that, the envisaged annual progress reports from the IDG have not been published.

8.25 While the annual progress reports have not been produced, there was significant effort put in to review of the strategy, with a view to ensuring that it could be re-focused, where necessary. The planned mid-term review of the strategy was published in March 2005. This resulted in revision/replacement of some of the original planned actions, and the addition of some new actions to the strategy. A further process of review and re-direction of the strategy was undertaken through the Working Group on Rehabilitation, which reported in May 2007.

8.26 In the main, the monitoring and reporting on the strategy that has taken place has tended to focus on the extent to which various actions outlined in the strategy have been implemented, rather than on the extent to which planned outputs and outcomes of treatment and rehabilitation services have been delivered.

8.27 The NACD has undertaken research into aspects of drug misuse in areas that treatment and rehabilitation services seek to have an impact e.g. homelessness, family support, etc. This kind of work is useful in providing benchmarks and context measures for performance monitoring and reporting, but does not represent a substitute for routine reporting on achievement of outputs and outcomes.

Measurement of Programme Performance

8.28 Assessment of the effectiveness of a programme requires, at a minimum, the identification of relevant measures of programme performance and the setting of realistic, time-bound targets for achievement. This principle was recognised in the development of the National Drugs Strategy, which included a set of key performance indicators for each of the pillars of the strategy.

8.29 The key performance measures adopted for the treatment and rehabilitation pillar are set out in Figure 8.3. Following the 2005 mid-term review, the performance indicators were revised and reduced in number.

Figure 8.3 Key performance indicators for treatment and rehabilitation pillar

Original key performance indicators (2001)

■ Have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment
■ Have access for under-18s to treatment following development of an appropriate protocol for dealing with this age group
■ Increase the number of treatment place for opiate addiction to 6,000 by end 2001 and to a minimum of 6,500 places by end 2002
■ Continue to implement the recommendations of the Steering Group on Prison-Based Drug Treatment Services as a priority and implement proposals designed to end heroin use in prisons during the period of the strategy
■ Have in place, in each Health Board area, a service user charter by end 2002
■ Have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002
■ Provide stabilised drug misusers with training and employment opportunities and, as a first step, increase the number of such opportunities by 30% by end 2004

Revised key performance indicators (2005)

■ 100% of problematic drug users accessing treatment within one month after assessment
■ 100% of problematic drug users aged under 18 accessing treatment within one month after assessment
■ Harm reduction facilities available, including needle exchange where necessary, open during the day and at evenings and weekends, according to need, in every local health office area
■ Incidence of HIV in drug users stabilised based on 2004 figures

Source: National Drugs Strategy 2001-2008; Mid-term review of the National Drugs Strategy, 2005

8.30 Some of the original key performance indicators in the National Drugs Strategy were expressed in terms of outputs or outcomes to be achieved within stated timeframes e.g. the target for a minimum of 6,500 places for methadone treatment by end 2002. Others did not specify key milestone dates for the achievement of targets e.g. the target of having immediate access to assessment and counselling. Some of the targets were short-term, in the context of a long-term (i.e. eight-year) strategy.

8.31 The set of key performance indicators adopted in 2005, in place of the original indicators, was less specific about what was to be achieved within what timeframe. Significant aspects of the performance of the treatment and rehabilitation system were not covered by the new indicators. For instance, the revised key performance indicators do not include highly relevant output or outcome measures such as

- timeliness of access to assessment
- percentage of cases for whom a treatment and rehabilitation plan has been completed

- measures of progression along the planned treatment path (including time on continuing treatment, such as methadone maintenance)
- timeliness of access to required support services, such as housing, training and childcare support
- outcomes of treatment including treatment completion and drop out rates.

8.32 Differentiation in target setting between the timeliness of provision of methadone maintenance and the timeliness of provision of other forms of treatment would also help to clarify the actual performance of the treatment and rehabilitation system.

Monitoring Programme Expenditure

8.33 The National Drug Strategy did not have a formal budget.

8.34 Drug addiction treatment and rehabilitation initiatives are provided by a wide range of agencies, many of whom provide multiple services and/or receive funding from a number of sources. Consequently, it is difficult to isolate the costs of treatment and rehabilitation services with precision. For example, the HSE provides some drug treatment as part of the psychiatric service, and has difficulty in identifying the level of funding applied for drug treatment only. Similarly, the Prison Service has traditionally treated drug treatment as part of the prison health spending, and has only recently begun to extract estimates of the cost of drug treatment.

8.35 Figure 8.4 draws together the available information about the expenditure of the various agencies on drug addiction treatment and rehabilitation services. This indicates that the total spending on such services in 2007 was in the region of €140 million.

8.36 How funding is distributed in terms of service outputs (e.g. methadone treatment, detoxification, residential rehabilitation) cannot readily be identified. The lack of information about the cost of treatment types limits the scope for evaluations of their cost-effectiveness.

Figure 8.4 Estimated funding of drug addiction treatment and rehabilitation services, 2007

	€m	€m
HSE/hospital/clinic treatment services		**58**
Drug Treatment Centre Board services		**10**
Primary care-based methadone treatment		**14**
Community and voluntary sector treatment and rehabilitation services		
Section 65 funding — HSE	12	
Mainstreamed drug task force projects — HSE	8	
Interim drug task force projects — DCRGA/HSE/FAS/Probation Service	16	
Probation service grants	3	**39**
Prison drug treatment and rehabilitation		**3**
FÁS Community Employment schemes		**16**
Total expenditure on drug treatment and rehabilitation		**140**

Source: HSE; Prison Service; DCRGA; Probation Service; FÁS

Formal Evaluation of the National Drugs Strategy

8.37 An overall evaluation of the effectiveness of treatment and rehabilitation services has not been carried out over the life of the National Drugs Strategy. However, some significant aspects of the services have been subject to evaluation studies. The key findings in some of these have been referred to in earlier chapters of this report e.g. the Research Outcome Study in Ireland (ROSIE), which evaluated the impact of various treatment types for opiate users; an evaluation of FÁS's special Community Employment schemes, the evaluation of the Drug Treatment Court pilot, and evaluation of the local drugs task forces.

Conclusions

8.38 A considerable amount of effort under the National Drugs Strategy has gone into the provision of structures and co-ordination mechanisms. Service delivery is effected through a variety of local projects.

Local projects, whether funded on an interim or mainstreamed basis, should be governed by service level agreements that specify the services to be provided and the standards to be met.

8.39 Concerns have been expressed about how well the system works, not least in the 2005 report of the mid-term review of the National Drugs Strategy, which drew attention to variable levels of commitment to making the structures work, discontinuity of representation and a lack of capacity to commit to decisions. The proposal in the 2007 Report of the Working Group on Drugs Rehabilitation to establish a further co-ordination structure for rehabilitation, and a separate pillar to focus more attention on the needs of service providers in that area, suggest that the existing co-ordination was not fully effective.

Co-ordination mechanisms need to be improved in order to ensure that consultation and decision-making structures are streamlined and effective.

8.40 The main focus in the monitoring of the National Drugs Strategy has been on progress in delivery of planned actions by the various responsible agencies. In addition, clear targets in terms of treatment and rehabilitation outputs and outcomes were not set. While a focus on implementing actions is necessary, it needs to be supplemented with programme achievement information so that the effect of those actions can be gauged.

The principal indicators should focus on two main delivery aspects — the availability of required treatment and the outcome of the treatment delivered. All targets should be time related.

8.41 The costs of treatment and rehabilitation services are not readily identifiable.

The cost of drug treatment and rehabilitation needs to be transparent.

Accordingly, a programme budget should be developed and expenditure on the various services should be tracked against budgets.

In order to provide accountability for performance, the outturns should be publicly reported each year.

Appendices

Appendix A Summary of the effects and use patterns of the most frequently used illicit drugs

Opiates

Heroin is derived from morphine, a naturally occurring substance extracted from the seed pod of the Asian poppy. Mainly taken by injection, it is a fast acting drug, resulting in an initial feeling of elation followed by a longer period of drowsiness. In addition to the physical and psychological effects of the drug itself, injecting may result in injury and infection, and brings high risks of HIV and hepatitis infection where injecting equipment is shared. Heroin overdose, often resulting in death, is a particular risk for users. Heroin is highly addictive, and chronic users can experience intense cravings for the drug even years after last use. Because the initial effects of the drug are short lived, addicts typically inject up to four times a day. Addiction to heroin usually has a destructive effect on the life of the user, with severe adverse impacts in many areas, including health, finances, employment and interpersonal relationships. It frequently results in chronic users being marginalised within society.

Methadone is a synthetic drug that is widely used as a controlled substitute for heroin, but may also be used on a non-prescribed basis ('street methadone'). It does not cause the kind of euphoria that is associated with heroin, and relieves both the craving for heroin and the symptoms associated with withdrawal. It also actively blocks the euphoric and sedating effects of heroin, thus reducing the incentive to take it. In Ireland, prescribed methadone is administered orally. Its effects typically last 24 to 36 hours in the human system, and so it is normally taken just once a day.

Non-Opiates

Cannabis, which is generally smoked, induces a relaxed feeling and mild hallucinations. It can influence mood and concentration, cause panic attacks and aggravate depression and schizophrenia. Misuse of the drug is most prevalent in the 15-24 age group.

Cocaine gives misusers a sense of confidence and can cause heightened aggression. Routes of administering the drug include sniffing, smoking and injecting. Cocaine can lead to raised blood pressure, respiratory failure, seizures and heart attacks. Traditionally regarded as a drug misused mainly by the wealthy, increased supply and falling prices has resulted in its more widespread use.

Crack cocaine is derived by heating ordinary cocaine powder in a solution of baking soda until the water evaporates and crystals are formed. Crack cocaine vaporises at a low temperature so it can be easily inhaled via a heated pipe. It produces a quick intense feeling of pleasure that is very short-lived. After effects may include anxiety, depression, irritability, extreme fatigue and paranoia.

Stimulants such as ecstasy and amphetamines, even in small doses, affect the body in much the same way as natural adrenaline. These drugs can cause panic attacks and hallucinations as well as heart difficulties. Stimulants have generally been associated with the popular dance scene.

Hypnotics and sedatives such as benzodiazepines are drugs which depress or slow down the body's functions with their effects ranging from reducing anxiety to inducing sleep. They can cause both physical and psychological dependence, and may be a problem for users of any age, including older people.

Appendix B National Drugs Strategy (2001-2008): Actions under the Treatment, Rehabilitation and Risk Reduction Pillar

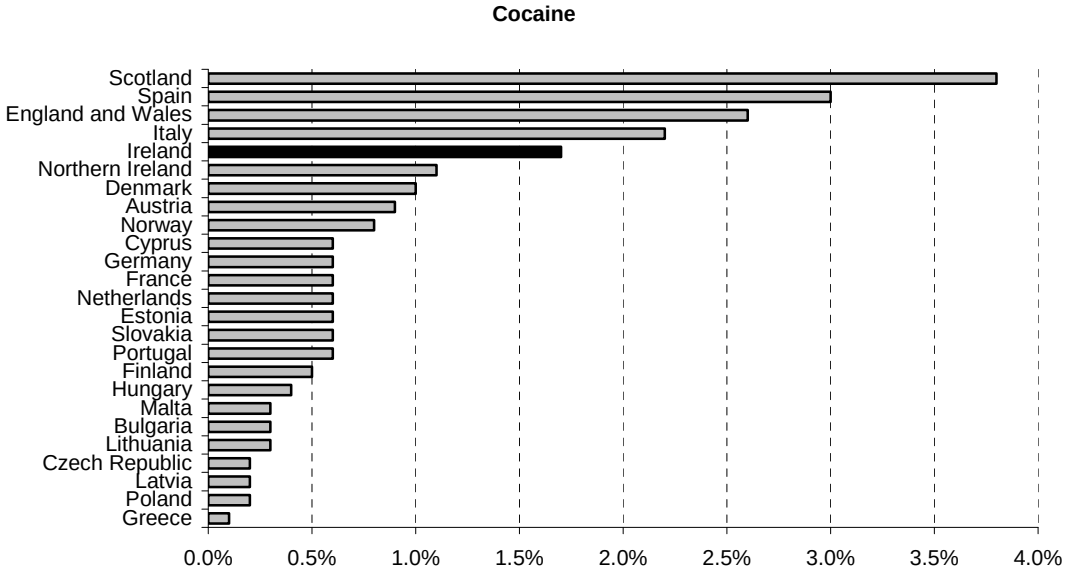
The National Drugs Strategy comprised 100 actions to be implemented by a range of public service agencies, under the four pillars i.e. supply reduction, prevention, treatment, and research. The actions relating to the treatment pillar are listed below. The numbers in brackets are those of the relevant action.

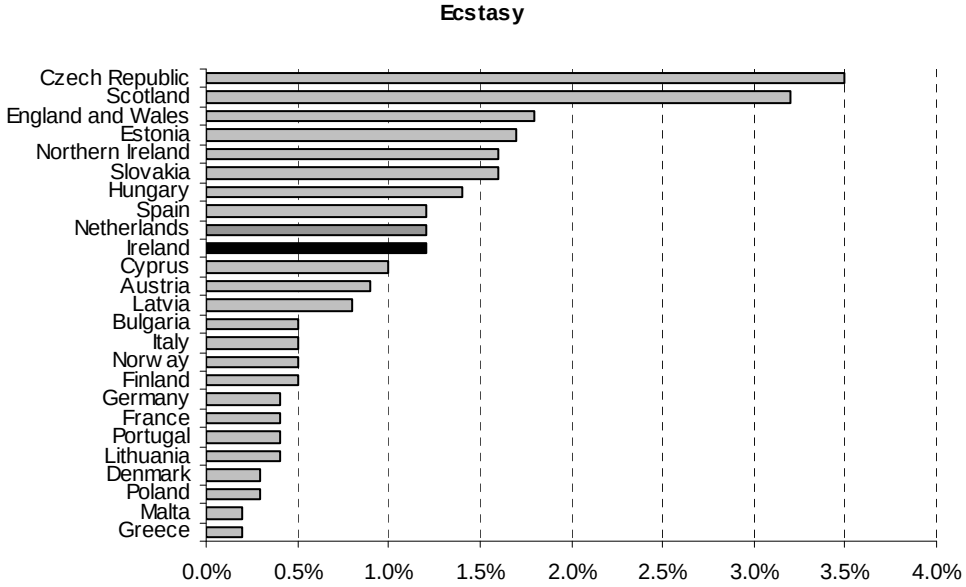
	Action
	Prison Services
1	To continue to implement the recommendations of the Steering Group on Prison-Based Drug Treatment Services as a priority and to implement proposals designed to end heroin use in prisons during the period of the Strategy. (Action 21)
2	To expand prison-based programmes with the aim of having treatment and rehabilitation services available to those who need them including drug treatment programmes, which specifically deal with the reintegration of the drug using offender into the family/community. (Action 22)
3	To commission and carry out an independent evaluation of the overall effectiveness of the Prison Strategy by mid-2004. The review should cover all aspects of drug services in prisons including research on levels and routes of supply of drugs in prisons. (Action 23)
4	To expand the involvement of the community and voluntary sectors in prison drug policy via the ongoing development of the Local Prison Liaison Groups and the formal meetings between the sectors and the Steering Group on Prison-Based Drug Treatment Services. (Action 24)
	Department of the Environment, Heritage and Local Government
5	To monitor and evaluate homelessness initiatives in relation to drugs issues in the context of the Homeless Strategy and particularly, in relation to the Dublin Action Plan. (Action 26)
	Department of Health and Children
6	To ensure that adequate training for healthcare and other professionals engaged in the management of drug dependency is available, including, if necessary, arrangements with third level institutions and professional bodies. (Action 39)
7	To consult all treatment and rehabilitation providers in order to ensure that performance indicators, used in the evaluation of services, accurately and consistently reflect the needs of specific areas i.e. performance indicators should reflect the reality of the drug problem locally. (Action 40)
8	To oversee implementation of the recommendations of the Benzodiazepine Working Group, which is due to complete its work by end June 2001, as part of the overall strategy of quality improvement of current services. (Action 41)
	Health Service Executive/Health Boards
9	To have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment. (Action 44)
10	To increase the number of treatment places for opiate addiction to 6,000 by the end of 2001 and to a minimum of 6,500 by the end of 2002. (Action 45)
11	To develop and put in place by end-2002 a service-user charter specific to treatment and rehabilitation facilities which would lead to a greater balance in the relationship between the service user and the service provider. Such a charter would be helpful to drug misusers presenting for treatment with low levels of educational attainment and/or low levels of self-esteem. (Action 46)

	Action
12	To base plans for treatment services on a "continuum of care" model and a "key worker" approach to provide a seamless transition between each different phase of treatment. This approach will enhance movement through various treatment and aftercare forms. In addition, the "key worker" can act as a central person for primary care providers (GPs and Pharmacists) to contact in connection with the drug misusers in their care. (Action 47)
13	To have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002. This approach will provide a series of options for the drug misuser, appropriate to his/her needs and circumstances and should assist in their re-integration back into society. (Action 48)
14	To develop a protocol, where appropriate, for the treatment of under 18 year olds presenting with serious drug problems especially in light of the legal and other dilemmas which are posed for professionals involved in the area. In this context, a Working Group should be established to develop the protocol. The Group should also look at issues such as the availability of appropriate residential and day treatment programmes, education and training rehabilitative measures and harm reduction responses for young people. The Group should report by mid-2002. (Action 49)
15	To develop, in consultation with the NACD, criteria to ensure that all State-funded treatment and rehabilitation programmes accord with quality standards as set out by the Health Boards. (Action 50)
16	To have a clearly coordinated and well publicised plan in place for each Health Board area by end 2002 for the provision of a comprehensive and locally accessible range of treatments for drug misusers, particularly for young people, the planning of such services to be linked to the national profile of drug misuse amongst young people and to the areas where usage is most prevalent. Plans to be implemented by 2004. (Action 51)
17	To produce and widely distribute a well publicised, short, easily read guide to the drug treatment services available in each Health Board area with contact numbers for further information and assistance. (Action 52)
18	To require from 2002 that all Health Boards, in considering the location and establishment of treatment and rehabilitation facilities, develop a management plan in consultation with local communities. Existing examples whereby Health Boards have established monitoring committees with the local community to oversee the operation of the treatment services have proven successful and should be replicated where appropriate. (Action 53)
19	To consider, as a matter of priority, how best to integrate child-care facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential treatment setting. This should be done in conjunction with the Department of Justice, Equality and Law Reform. (Action 54)
20	To explore immediately the scope for introducing greater provision of alternative medical and non-medical treatment types, which allow greater flexibility and choice. This may increase the number of drug misusers presenting for treatment, as it is evident that a "one size fits all" approach is not appropriate to the characteristics of Irish drug misuse. (Action 55)
21	To consider as a matter of priority, how to increase the level of GP and pharmacy involvement in the provision of treatment programmes. Increased capacity at the primary care level will have the effect of alleviating the pressure on the secondary care services which are currently oversubscribed. (Action 56)
22	To oversee the development of comprehensive residential treatment models incorporating detoxification, intervention, pre-treatment counselling, motivational work, therapeutic treatment and high quality rehabilitation for misusers who wish to become drug-free. Resources should continue to be targeted at the most efficient and effective of these services. (Action 57)
23	To report to the NACD on the efficacy of different forms of treatment and detox facilities and residential drug-free regimes on an ongoing basis. (Action 58)

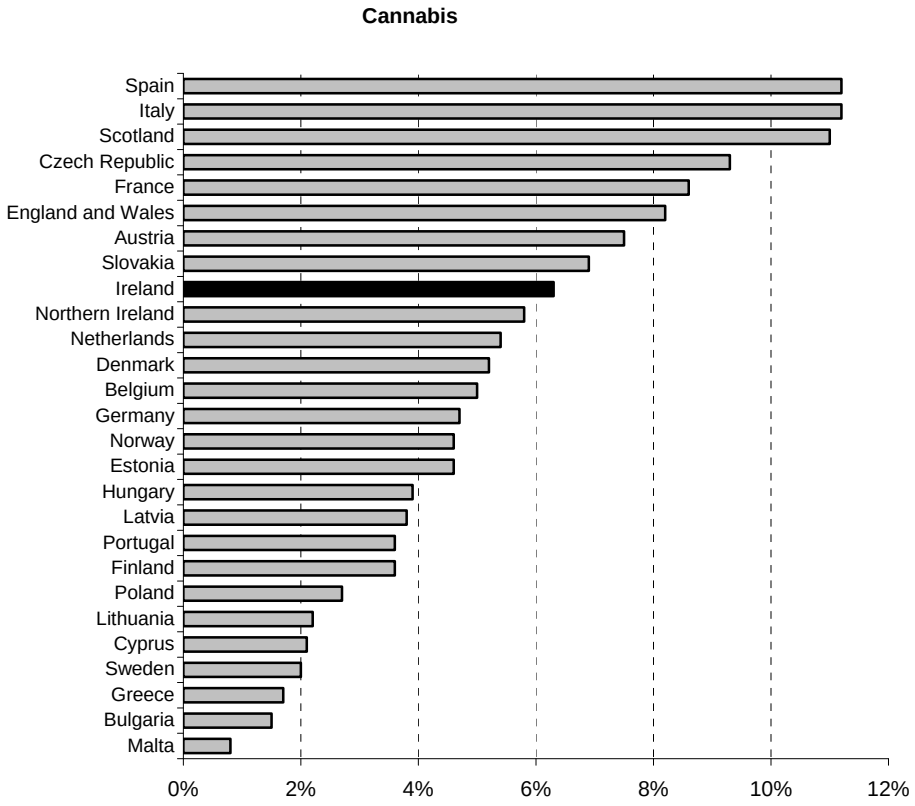
	Action
24	To secure easy access to counselling services for young people seeking assistance with drug-related problems, especially given the correlation between suicide and drug misuse and the growing incidence of suicide amongst young people (Action 59)
25	To ensure that treatment for young people includes family therapy and community integration phases, in order to encourage family involvement which is a crucial component in the treatment of young people. (Action 60)
26	To consider developing drop-in centres, respite facilities and halfway houses, where a clear need has been identified, as such facilities have been found to be useful in the prevention of relapse. (Action 61)
27	To review the existing network of needle exchange facilities with a view to ensuring access for all injecting drug misusers to sterile equipment. (Action 62)
28	To pursue with the relevant agencies, as a matter of priority, the setting up of a Pilot Community Pharmacy Needle and Syringe Exchange Programme in the ERHA area, and in the event of a successful evaluation, the programme to be extended where required. (Action 63)
29	To continue to develop good practice outreach models, including mechanisms to outreach drug misusers who are not in contact with mainstream treatment or support agencies. A reduction in the level of drug-related deaths, particularly from opiate misuse, through targeted information, educational and prevention campaigns, must be a key aspect of the Strategy. (Action 64)
30	To consider the feasibility of new suitably trained peer-support groups in the context of expanded provision. Peer-support groups are a component of the existing strategy and are regarded as an effective rehabilitative support. (Action 66)
Local Authorities and Health Boards	
31	To achieve close liaison between treatment providers, social workers, probation and welfare officers and the relevant local authorities as well as family supports, so as to ensure that recovering misusers should have access to housing. This is very important in ensuring that the effectiveness of treatment and the goals of rehabilitation are not undermined. (Action 68)
32	To develop and implement proposals for the collection and safe disposal of injecting equipment, in order to ensure that the wider community is not exposed to the dangers associated with unsafe disposal. (Action 69)
County Development Boards	
33	To consider the needs of those areas experiencing high levels of drug misuse when drawing up city/countywide strategies for economic, social and cultural development. (Action 71)
FÁS	
34	To increase the number of training and employment opportunities for drug misusers by 30% by end 2004, in line with the commitment to provide such opportunities in the PPF and taking on board best practice from the special FÁS Community Employment Programme and the Pilot Labour Inclusion Programme. (Action 74)
35	To examine the potential to involve recovering drug misusers in Social Economy projects and in other forms of vocational training. The ring-fencing of places within the FÁS Community Employment Programme has been an important element of the existing approach to rehabilitation. (Action 75)
36	To monitor the participation of recovering drug misusers on such programmes and to review their overall effectiveness. In this context, alternative models should be developed where appropriate. (Action 76)

Appendix C Last Year Prevalence Rates for Drug Misuse in EU Member States [1]





1 Statistical Bulletin 2008, European Monitoring Centre for Drugs and Drug Addiction.


Cannabis
Spain
Italy
Scotland
Czech Republic
France
England and Wales
Austria
Slovakia
Ireland
Northern Ireland
Netherlands
Denmark
Belgium
Germany
Norway
Estonia
Hungary
Latvia
Portugal
Finland
Poland
Lithuania
Cyprus
Sweden
Greece
Bulgaria
Malta
0%
2%
4%
6%
8%
10%
12%

Appendix D NDTRS Case Reporting Form

National Drug Treatment Reporting System (NDTRS)

Drug Misuse Research Division, Health Research Board

HRB

A. Administrative details

Name _____ Address _____

1. HSE Area (see Appendix 2) ☐☐ **2a. Centre** ☐☐☐☐☐ **2b.Type** (see Appendix 3) ☐☐ **3. Client number** ☐☐☐☐☐☐☐☐☐☐☐☐

B. Demographic details

4. Gender (circle) 1. Male 2. Female

5. Age (years) ☐☐

6. Date of birth ☐☐ Day ☐☐ Month ☐☐ Year

7a. Living with whom (circle)
1. Alone 2. Parents/family 3. Friends 4. Partner (alone)
5. Partner & child(ren) 6. Alone with child(ren) 7. Other
9. Not known (If other, please specify) _____

7b. Living where (circle)
1. Stable accommodation 2. Institution (prison/residential care/halfway house) 3. Homeless
4. Other unstable accommodation 9. Not known

8a. Area of residence (specify) ☐☐☐
_____ (DED, pink book or Appendix 4)

8b. Community Care Area ☐☐☐☐
_____ (see Appendix 5)

9. City/county (specify code) (see Appendix 6) ☐☐ Car registration code

10. Nationality (If Irish circle, otherwise specify)
1. Irish 2. Other 9. Not known
nationality _____

11. Employment status (circle)
1. In paid employment 2. Unemployed
3. FAS/training course 4. Student
5. Housewife/husband 6. Retired/unable to work
8. Other (please specify) _____ 9. Not known

12a. Age left primary or secondary school (not third level)
(years, or circle code below) ☐☐ years
01. Never went to school
88. Still at school
99. Not known

12b. Education: highest level completed (circle)
0. Primary level incomplete
1. Primary level 2. Junior cert
3. Leaving cert 4. Third level
5. Never went to school
6. Special needs education
8. Still in education
9. Not known

C. Referral/assessment details

13. Date of referral ☐☐ Day ☐☐ Month ☐☐ Year

14. Main reason for referral (based on main problem drug, circle)
1. Alcohol 2. Illicit drug 3. Licit drug
Specify main drug _____

15. Source of referral (circle)
1. Self 2. Family 3. Friends
4. Other drug treatment centre 5. General practitioner
6. Hospital/medical agency
7. Social services/Community services
8. Court/probation/police 10. Outreach worker
11. Mobile bus 12. School 13. Prison
14. Employer 99. Not known

16. Date of assessment ☐☐ Day ☐☐ Month ☐☐ Year

17. Assessment outcome (circle)
1. Suitable for treatment 2. Unsuitable for treatment

(if 2, STOP. Ensure Q14 is complete and send form to HRB)

18. Client's treatment status (circle)
1. Offered treatment place 2. Placed on waiting list
3. Referred or transferred to another site
(specify) _____
4. Psychiatric assessment
(if 1 or 2, continue form when treatment commences.
If 3, specify the site. If 3 or 4, STOP. Ensure Q14 is complete and send form to HRB)

19. Accepted place at this treatment agency (circle)
1. Yes 2. No
3. Yes, but place not offered within calendar month
(if 2, STOP. Ensure Q14 is complete and send form to HRB)

D. Treatment details

20. Number of times started treatment in this centre this year (Jan - Dec 2006)
(excluding continuous care and previous referrals or assessments)
(Enter 1, if first time this year) ☐☐ (times)

21a. Date THIS treatment started ☐☐ Day ☐☐ Month ☐☐ Year

21b. If receiving an opiate substitute (methadone) date substitution started ☐☐ Day ☐☐ Month ☐☐ Year

22. Ever previously treated for problem drug or alcohol use
(if main problem is alcohol, circle appropriate answer in alcohol options or if main problem is a drug, circle appropriate answer in drug options)
Alcohol 1. Never treated 2. Previously treated 8. Not applicable 9. Not known
Drug 1. Never treated 2. Previously treated 8. Not applicable 9. Not known

23. Type of contact with this centre (circle)
1. First treatment 2. One or more treatment periods 9. Not known

E. Substance use

24a. Age first used any drug (excluding alcohol and tobacco) ☐☐ years (if not applicable code 88)

24b. Specify first drug used (excluding alcohol and tobacco) _____

a. Problem substance(s) including alcohol (write in words)	b. Route of administration (use codes: 1. Inject; 2. Smoke; 3. Eat/drink; 4. Sniff/snort/inhale; 5. Sublingual; 6. Rectal; 7. Topical; 9. Not known)	C. Frequency of use in last month (use codes: 1. Once a week, or less; 2. 2-6 days per week; 3. Daily; 4. No use in past month; 9. Not known)	d. Age at first use (years if unknown 99)
25. Main substance name			
26. Substance 2 name*			
27. Substance 3 name			
28. Substance 4 name			

* In addition to the main problem substance, record any secondary substances that are part of the client's CURRENT problem alcohol or drug use.

F. Risk behaviour

29a. Injected in past month (circle) 1. Yes 2. No 9. Not known

29b. Ever injected (circle) 1. Yes 2. No 9. Not known

29c. If yes, age first injected ☐☐ years (if not applicable code 88)

30. Ever shared any injecting equipment (circle)
1. Yes 2. No 8. Not applicable 9. Not known

For official use only:
32. Quarter which data pertains to (for performance indicators, circle)
1. Quarter 1 (Jan-March) 2. Quarter 2 (April-June) 3. Quarter 3 (July-Sept) 4. Quarter 4 (Oct-Dec)
(If treated, then quarter treated. If assessed only, then quarter assessed)

G. Initial action(s)

31. Type(s) of initial intervention provided at this centre during THIS TREATMENT
(may circle more than one initial action)
1. Brief intervention
2. Alcohol detoxification
3. Benzodiazepine detoxification
4. Detoxification symptomatic medication
5. Opiate detoxification (buprenorphine)
6. Opiate detoxification (lofexidine)
7. Methadone detoxification
8. Substitution (methadone)
9. Substitution (using other opiate)
(specify) _____
10. Substitution using non-opiate drug
(specify) _____
11. Substitution (drug, name unknown)
12. Medication-free therapy
(psychosocial therapy, therapeutic community, Minnesota Model etc)
13. Psychiatric treatment
14. Counselling
15. Social and/or occupational reintegration
16. Family therapy
17. Education/Awareness programmes
18. Complimentary therapies
19. Referred or transferred to another site
(specify) _____ **(send form to HRB)**

National DrugTreatment Reporting System (NDTRS)

Drug Misuse Research Division, Health Research Board

Guidelines for data collection 2006

One form should be completed for each individual who starts or returns to treatment for problem drug or alcohol use in a calendar year (January to December).

Each client should have a unique client number (question 3) assigned by the treatment agency. This can be the case notes number or whatever numbering system is most appropriate for the participating treatment provider. The number on the form should be linked to the case notes so that treatment providers can deal with queries effortlessly.

Service providers complete sections A, B and C of the National Drug Treatment Reporting System form during the initial assessment and sections D, E, F and G during the first treatment contact with each client who attends in a given year.

When the form is complete: **Duplicate page** – return to Health Research Board
Top page – place in client's case notes

Definitions

Referral can be defined as directing a person to a source for help, information or treatment in relation to problem drug use.

Assessment is an evaluation of an individual's needs. The aim of assessment is to identify the requirements of the individual in order to inform decisions about treatment, care and support. It usually takes the form of one-to-one discussions between a staff member and the individual.

Treatment is:

- Any activity targeted at people who have problems with substance use (excluding tobacco), and which aims to improve the psychological, medical and social state of individuals who seek help for their problem drug use
- One or more of the following: medication (detoxification, methadone reduction and substitution programmes), addiction counselling, group therapy, psychotherapy and/or life skills training
- Provided in both residential and non-residential settings.

Never treated refers to a client who has never received treatment for the main problem substance (alcohol or drugs) anywhere or at any time in the past.

Previously treated refers to a client who has received treatment for the main problem substance (alcohol or drugs) at some point in the past, either from this treatment centre or from any other treatment centre.

Sharing injecting equipment refers to whether the client has ever shared injecting equipment. This includes needles, syringes, spoons, filters, citric, water to mix drug, water or bleach to clean equipment.

Appendix 4: Area of residence

Codes Health Board Areas Pink book - Look up specific DED code for Dublin, Kildare and Wicklow.

Counties

711 – Carlow
732 – Cavan
720 – Clare
721 – Cork County
700 – Cork City
733 – Donegal
727 – Galway County
742 – Galway City
722 – Kerry
712 – Kilkenny County
710 – Kilkenny City
713 – Laois
728 – Leitrim
723 – Limerick
740 – Limerick City
714 – Longford
715 – Louth
729 – Mayo
716 – Meath
734 – Monaghan
717 – Offaly
730 – Roscommon
731 – Sligo
724 – Tipperary NR
725 – Tipperary SR
726 – Waterford
741 – Waterford City
718 – Westmeath
719 – Wexford

Outside Ireland

755 – America, Africa, Asia, Australia
751 – Northern Ireland
753 – Other EU
754 – Other European (outside EU)
752 – UK

Ireland Unknown

(only to be used if detailed address information cannot be obtained)

499 – Dublin, not known
599 – Kildare, not known
699 – Wicklow, not known
995 – HSE Midland Area, not known
997 – HSE Mid Western Area, not known
998 – HSE North Eastern Area, not known
999 – HSE South Eastern Area, not known
993 – HSE Southern Area, not known
996 – HSE Western Area, not known
994 – HSE North Western Area, not known
702 – Ireland, otherwise unclassifiable

701 – Address missing

Forms are available from:

Siobhán Reynolds
(Dublin, Kildare and Wicklow areas, excluding Trinity Court. All General practice forms)

or

Sarah Fanagan
(HSE areas in the North East, Midlands, South East, South, Mid-West, West and North West as well as Trinity Court)

Drug Misuse Research Division
Health Research Board
Holbrook House,
Holles Street
Dublin 2
tel 01 676 1176
fax 01 661 8567
email drnrd@hrb.ie
web www.hrb.ie

Main problem substance

Problem substance use is the taking of any legal or illegal substance which harms the physical, mental or social well being of the individual, the group or society. The main categories of drugs included in the reporting system are:

- Alcohol
- Amphetamines and amphetamine-type central nervous system stimulants, including ecstasy
- Barbiturates and other sedative-type hypnotics, including benzodiazepines
- Cannabis
- Cocaine and coca products, including crack
- Hallucinogens
- Heroin
- Substitute opiate-type drugs
- Other licit and street opiate-type drugs
- Volatile inhalants
- Other psychoactive substances

Appendix 2

Code	Health Service Executive Area	Code	Health Service Executive Area
03	HSE Southern Area	08	HSE North Eastern Area
04	HSE North Western Area	09	HSE South Eastern Area
05	HSE Midland Area	11	HSE East Coast Area
06	HSE Western Area	12	HSE South Western Area
07	HSE Mid Western Area	13	HSE Northern Area

Appendix 3

Code Type

99 Missing

Specialised residential

11 Hospital inpatient unit
12 Therapeutic community
14 Other specialised residential treatment

Specialised non-residential

21 Hospital outpatient treatment centre
22 Day centre/hospital
23 Local health care/social service centre
24 Low threshold
25 Other specialised non-residential

Based in general services

31 Inpatient psychiatric hospital/unit
32 Outpatient mental health care centre
33 General practitioner
34 Residential social care facility
35 Non-residential social care facility
36 Other non specialised non-residential centre
37 Primary care

Prisons

41 Treatment in prison

Appendix 5

Community Care Area

Community Care Area	DED Code	Community Care Area Code
Community Care Area 6	1-7, 11-14, 20, 27, 30-36, 63-69, 82, 139, 208-217, 220, 214.	1306
Community Care Area 7	9-10, 15-19, 21, 24-26, 28-29, 42-45, 47-50, 58-60, 70, 80-81, 104-109, 138, 157-160, 201, 242.	1307
Community Care Area 8	8, 22-23, 41, 46, 62, 71-77, 86-89, 119-126, 202,-207, 218-219, 221-226, 228-240.	1308
Louth	715	0801
Meath	716	0802
Cavan/Monaghan	732/734	0803
Community Care Area 1	407-421, 432-436, 442-456, 456-466.	1101
Community Care Area 2	111-114, 116-117, 128-131, 401-406, 422-431, 437-441, 457, 469.	1102
Wicklow (East coast)	601-607, 632-683	1110
Community Care Area 3	96-103, 110, 115, 127, 132-137, 140-153, 161-162, 302, 311-313, 322-326.	1203
Community Care Area 4	51-56, 90-94, 154-156, 301, 303-304, 314, 328-349.	1204
Community Care Area 5	37-40, 57, 61, 76-79, 83-85, 95, 118, 227, 305-310, 315-321, 327.	1205
Kildare (Area 9)	501-590	1209
Wicklow (Western Area)	608-631	1209
Longford	714	0501
Offaly	717	0502
Westmeath	718	0503
Laois	713	0504
Carlow/Kilkenny	711/712/710	0901
Tipperary SR	725	0902
Wexford	719	0903
Waterford	726/741	0904
Cork - North Lee	700/721	0301
Cork - South Lee	700/721	0302
North Cork	700	0303
West Cork	700	0304
Kerry	722	0305
Donegal	733	0401
Sligo/Leitrim	731/728	0402
Galway	727/742	0601
Mayo	729	0602
Roscommon	730	0603
Limerick	723740	0701
Clare	720	0702
Tipperary NR	724	0703

Appendix 6

Code	County or city or area	Code	County or city or area	Code	County or city or area
CW	Carlow	KE	Kildare	RN	Roscommon
CN	Cavan	K	Kilkenny City	SO	Sligo
CE	Clare	KK	Kilkenny County	TN	Tipperary NR
NL	North Lee (Cork)	LS	Laois	TS	Tipperary SR
SL	South Lee (Cork)	LM	Leitrim	W	Waterford City
NC	North Cork	L	Limerick City	WD	Waterford County
WC	West Cork	LK	Limerick County	WH	Westmeath
DL	Donegal	LD	Longford	WX	Wexford
D	Dublin City	LH	Louth	WW	Wicklow
DN	Dublin County	MO	Mayo	XX	Outside Ireland
G	Galway City	MH	Meath	ZZ	Not known
GY	Galway County	MN	Monaghan		
KY	Kerry	OY	Offaly		