Irish addiction services – past, present and future

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To discuss the development of addiction services into the future, one must first examine the historical response to the misuse of substances in this country. A brief overview reveals wide disparity between, the treatment of opioid dependence in the east of the country and the way statutory services deal with the significant problem of alcohol misuse. A comprehensive model is required to deal with addiction on a national basis that necessitates the amalgamation of the drug and alcohol services.

The National Advisory Committee on Drugs (NACD) in Ireland and the Drug and Alcohol Information and Research Unit (DAIRU) in Northern Ireland have documented the extent of the problem for the island of Ireland in 2002/2003. The lifetime prevalence for any illicit drug use is 19% in the age group 15-64 years and the lifetime prevalence for alcohol use is 91% for the same age group.[1] The main illicit drug is cannabis with 24.4% of young adults (15-34 years) reporting lifetime use. It is also interesting to note that 4% in this age group have used cocaine and 0.6% have used heroin.

The response of the health services in the early 1990s to the problem of heroin dependence was largely driven by public health. The growing numbers of injecting drug users infected with HIV led to the development of a harm reduction policy, encompassing needle exchange, education for drug users and methadone maintenance. Allied to this approach was the provision of significant resources by a government that recognised the drugs problem as a serious issue of public concern. There was the coming together of statutory, community and voluntary services to produce a community-based model of addiction treatment involving primary care with a focus to provide services for the individual drug user at a local level. There are currently over 7500 individuals in receipt of methadone treatment in Ireland with approximately one third of these attending a general practitioner. The remainder are treated at a network of community based clinics many of which involve close partnership between the health services and the local community. There are approximately 60 such clinics in the greater Dublin area and six in the rest of the country located in Portlaoise, Athlone, Carlow, Waterford, Limerick and Galway.

This current approach to the treatment of substance misuse however has not been without its critics. Some have described it as an 'opioid only service', while others suggest that what has emerged is simply a highly developed and organised 'methadone delivery service'. In addition, more recently as resources for statutory services have remained static, community groups have been applying for funding for treatment initiatives via the National Drugs Strategy. While these groups do not have the concerns of the statutory services around staff ceilings, for example, it is vitally important that these treatment initiatives are provided by trained professionals and are subject to intensive scrutiny and audit so that they may conform to professional quality norms. Thus for example, a needle exchange programme provided by the community and funded by the National Drugs Strategy team should meet and maintain appropriate standards. Careful monitoring of the impact of such a development would be required by for example, documenting the levels of blood borne viruses within that community on an ongoing basis.

In contrast to the resources provided for the development of drug services, the provision of resources for alcohol services has been grossly inadequate. During this period of lack of resources, per capita drinking in Ireland increased dramatically. Between 1989 and 2000 per capita alcohol consumption in Ireland increased by 41% and in 2001 Ireland had the second highest per capita consumption of alcohol in the enlarged EU.[2] The SLAN survey in 2002 highlighted the fact that 30% of males and 22% of females consumed more than the recommended weekly limits of sensible alcohol consumption.[3] The ESPAD report of 1999 showed that Irish 16 year olds are among the highest alcohol abusers in Europe in terms of binge drinking and drunkenness.[4]

The contribution of alcohol to morbidity and mortality is well documented. In 2002, the WHO identified alcohol related death and disability as accounting for 9.2% of all burden of disease in developed countries behind tobacco and hypertension.[5] Irish healthcare costs for alcohol in 2003 were estimated at €433 million, however the vast majority of these costs were related to treating the consequences of alcohol abuse with only a small provision for alcohol treatment.[6] In many cases, alcohol counsellors provide services for individuals with alcohol problems in isolation from other supports such as multidisciplinary mental health teams. For psychiatric services it should also be noted that in 2002 alcoholic disorder was the second highest cause of admission to psychiatric hospitals for males and the fourth highest cause for females.[7] Developing an effective community based alcohol service would reduce considerably this admission rate.

The recent Strategic Taskforce on Alcohol second report in 2004 gave specific recommendations to reduce consumption and limit harm within the population.[8] These included, decreasing availability, increasing taxation and putting in place effective treatment services utilising specialist treat-

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ment. The government has ignored these recommendations.

More recently dual diagnosis (co-existence of serious mental health disorder and an addictive disorder) has gained increasing recognition in this country as elsewhere. The National Household Study in the UK found psychological morbidity present in 12% of non-dependent individuals, 30% of alcohol dependent individuals and 45% of drug dependent individuals.[9] In the Comorbidity of Substance Misuse and Mental Illness Collaborative study (COSMIC), 40% of patients managed in community mental health settings reported problem drug use and/or harmful alcohol use in the past year.[10] Unless the individual receives appropriate interventions for both conditions then outcomes in this cohort will remain poor and relapses high.

Various models have been proposed to deal with dual diagnosis. These include the serial model (one condition treated after another), the parallel model (the two services work together to treat the individual with joint planning and liaison) and the integrated model (dedicated team to treat both conditions). Although the integrated model has found favour in the US, there is inconclusive evidence for this expensive approach.[11] An integrated model may result in isolation of dual diagnosis from mainstream services and staff in mainstream services may become deskilled. A care programme approach as advocated by the Mental Health Policy Guide in the UK may have merit.[12] This approach advocates co-ordination between mental health teams and substance misuse teams and closer links in terms of training and supervision and the augmentation of teams with a dual diagnosis worker.

In addition to the recognition of strong links between addiction services and mental health services, there are a number of links with other healthcare providers which would benefit patients. Primary care can play a pivotal role in the detection, evaluation and treatment of drug and alcohol abuse. While good links have been established between the drugs services and primary care, these could be strengthened in relation to alcohol services. Liaison between maternity and drug services improves antenatal care and decreases neonatal morbidity particularly in the case of opioid dependence.[13]

For HIV services, supervision of antiretroviral therapy at methadone treatment clinics can improve the adherence to and outcome for treatment.[14] Closer links with hepatology services could improve hepatitis C treatment outcomes with supervision of interferon and ribavirin for infected drug users at addiction centers. For accident and emergency services it has been demonstrated that brief interventions for alcohol related problems on-site can reduce reattendance.[15] Prison healthcare services and homelessness services will benefit from stronger links with addiction services given the high levels of substance misuse among these cohorts. Continuation of care in relation to individuals recently released from prison is a vital factor in the reduction of fatal overdose for this group. One further area where substance misuse services could contribute an intervention could be in services to the elderly. The problem of long-term benzodiazepine use and also alcohol abuse in individuals over the age of 65 has been recognised. Up to 20% of female general medical services patients in this age group have been shown to be in receipt of scripts for benzodiazepines over a three-month period.[16] To date, no effective strategies have been implemented to address this concern.

The treatment of substance misuse problems in young people under the age of 18 is one area where Ireland can justifiably claim to be at the forefront of international practice. The appointment of consultant child and adolescent psychiatrists in substance misuse and the provision of some resources to develop a service is a welcome innovation and the outcomes for such a strategy are awaited with interest.

Clearly addiction problems impact significantly on a broad spectrum of other health domains. Currently the drug and alcohol services in Ireland are operating by and large independently of one another. The rational for combining these services, one of which has received significant funding for mainly political reasons while the other has received little funding, perhaps also for political reasons, is now becoming irrefutable. Co-dependence on drugs and alcohol occurs frequently among individuals particularly in younger age groups.[17] Treatment approaches used in the management of addiction are similar. Professional competencies of staff working in the areas of drug and alcohol dependence are similar. A combined service would improve the support provided to primary care in the area of alcohol treatment. A combined service is more likely to meet the needs of both sets of patients. By integrating the services, resources for addiction could be lobbied for more effectively and allocated according to need particularly in the case of alcohol services nationally.

The future development of addiction services requires a combined drug and alcohol service under the umbrella of mental health. Linkages with other health providers need to be strengthened through the appointment of liaison workers and improved communication and co-operation. Research into the area of addiction needs to be supported and developed further in order that effective and quality focused services can be implemented and maintained. This may require the setting up of a strong academic base and programme in the context of a National Addiction Centre similar to the UK. For services to be effective, sufficient resources are required to develop a comprehensive model. Under the new Health Services Executive structure, each local health area in the country will need access to an addiction service under the direction and leadership of a consultant psychiatrist in substance misuse. The success and experience of the drugs service in developing a community based treatment service involving statutory, community and voluntary agencies can provide a template for a similar approach in relation to alcohol services. This should complement and enhance the implementation of the national alcohol strategy.

Declaration of interest: None

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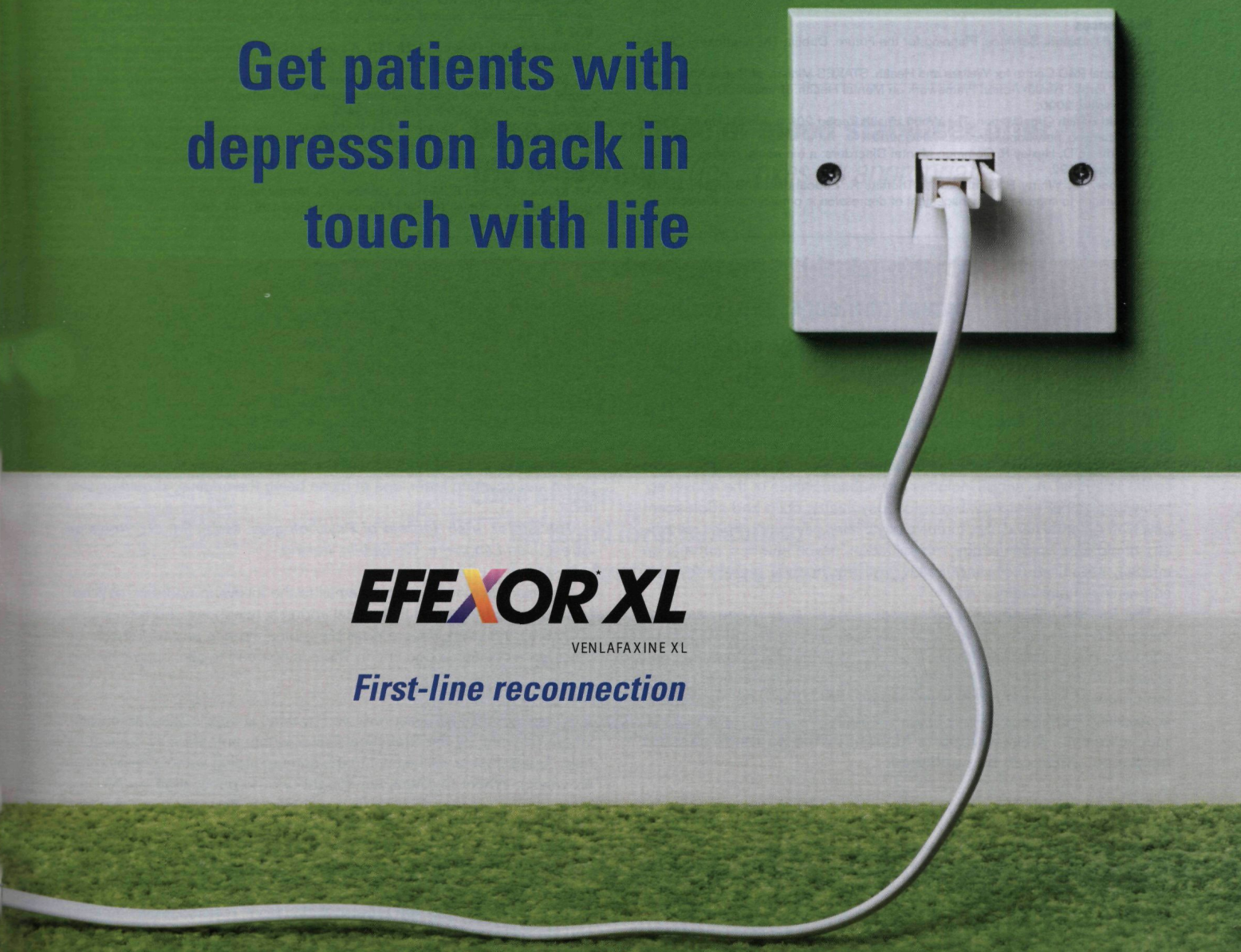

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