NOVAS COMMUNITY DETOX PROGRAMME EVALUATION: FIDELITY, CLIENT AND PROGRAMME OUTCOMES

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FOREWORD

FOREWORD BY ANNE CRONIN

This evaluation of the Community Detox is highly anticipated by Novas for many reasons. When we first began to consider options for our service users and their accessibility of drug treatment services, we were introduced to the model of community detox treatment. We identified that it was an option that was readily accessible and provided an immediate response to those who were looking to engage in treatment around their benzodiazepine and methadone use. We accessed the model through the Ana Liffey service who had designed the protocols with Progression Routes.

Novas envisaged the Community Detox as one of many potential solutions to support homeless service users to detoxify from benzodiazepines and methadone, however over time the wider community in the Mid-West has been the main benefactor of the service. The Community Detox in its current format is reaching many homes throughout the region where for one reason or another the person in addiction cannot access residential drug treatment services. For some they continue to care for their families and children and leaving for residential treatment is not an

option. For others, confidence is an issue and group work (which is a feature of many programmes) is problematic. Whatever their own personal reason for accessing the Community Detox, over 130 people in the region have chosen to access drug treatment via this model in the period May 2012 to June 2015.

This service sits within a range of other drug treatment services that attempt to offer as wide a choice as possible for those who want to access drug treatment. Research shows us that when you have a wide, disperse population with a combination of needs, the response to meet those needs also needs to be diverse. The Community Detox holds a unique position in the Mid West's suite of drug treatment responses and has provided a regional and national picture that was heretofore not present. Those who access this service are clear evidence of the continued need for bespoke services that respond to the ever-changing dynamic that a drug user might find themselves in. Our mothers, fathers, grandparents, siblings, children need our support when drug treatment is requested – the Novas Community Detox is one such response that is meeting a growing need in the region.

The Community Detox is a funded service and employs three part-time staff, which is key to its success to-date. In other regions Community Detox has been offered in a volunteer-led capacity and numbers anecdotally have been much lower than those referred to the Novas Community Detox. Services like this, need to be adequately resourced for solid and meaningful outcomes. Novas works very closely with the Mid West Regional Drug and Alcohol Forum who have funded the service in partnership with the HSE since its inception in 2012. Without this support, we would not have as many accessing or remaining in the service. This model is a clear demonstration of successful resource allocation meeting the identified need in a community.

Novas are heartened by the successful outcome of this evaluation and take it as a green light to expand the protocols to cover other areas of addiction that are being increasingly referred to the service; alcohol, cannabis and heroin to name but three. Novas has been supporting people with drug-related issues since we opened our first low-threshold homeless service in Limerick in 2002, operating within a harm reduction model. Over the past 14 years, we have developed many housing services as well as health and recovery based initiatives. We view the Community Detox as a very successful health initiative that will continue to provide routes for those who want to tackle their benzodiazepine and methadone use and other drugs into the future.

Finally, I wish to thank Ronni Greenwood for carrying out this evaluation and treating the data with the care and attention it deserved. I also want to thank the staff in the service, without whom, it would not be as successful as it is today; Julie McKenna, Maurice Crowe and Dan Taylor. Thank You.

Anne Cronin

INTRODUCTION

01

Introduction

History and Context of Novas Initiatives Community Detox Programme Evaluation

In 2007, an Expert Group came together in Dublin to discuss and respond to community members' reports that they could not access needed detoxification services (O'Reilly, Reaper, & Redmond, 2005). Then, as now, available residential detox supply could not meet demand. Limited funding for inpatient resources and intake criteria exclude many people from needed inpatient services. Outpatient detox is not an option for most of these individuals, because general practitioners are reluctant to provide this service for a number of reasons, including increased risk of overdose, prescription abuse, and insufficient psychosocial supports to facilitate outpatient detox (Progression Routes, 2011). As a consequence, many members of the community who had both need for and motivation to detox had no means through which to do so.

In response to this need, the Expert Group formed a multidisciplinary steering committee composed of addictions experts. This group came together with Progression Routes Initiative (PRI) to draft a protocol for community-based detox. The protocols outline a set of minimum standards for medical and psychosocial support for community-based detox that are aligned with national strategic documents (e.g., Doyle & Ivanovic, 2010; HSE, 2010). The minimum standards for a community-based detoxification outlined in the protocols are: provision of interagency care planning, relapse prevention, and medical supports (Progression Routes, 2011).

Once the initial protocols were finalized, they were pilot tested for 18 months beginning in April 2007 in the North Inner City region of Dublin. This single-site community detox program was evaluated in early 2009. PRI reported generally positive client outcomes and cost effectiveness findings (Progression Routes, 2011, p. 5). In 2010 an expanded Community Based Detoxification Steering Group came together and revised the protocol in light of the pilot evaluation findings. In 2011, local and regional drugs tasks forces were invited to participate in a national community-based detoxification pilot programme (Dermody & Lyons, 2011; Progression Routes, 2011).

In 2012, when the Midwest Regional Drug Task Force released a Call for Expression of Interest for experienced drugs services providers to apply for funding for treatment and rehabilitation initiatives for substance misusers in the Midwest Region, Novas Initiatives responded with an application for funding to participate in the national community detox pilot programme on the basis of findings from

a phenomenological study of self-detoxification (van Hout & Bingham, 2012), of the experience gained in the first six months of the Novas CD programme, and because of the gap in services caused by a lack of available funding for full residential detox service. With these funds, Novas Initiatives aimed to create and deliver a community detox team within the umbrella of their homeless services at McGarry House, which is a low threshold hostel accommodation in Limerick City. At the time, a significant number of McGarry House residents misused benzodiazepines but could not avail of residential detox services because they did not meet eligibility criteria and because waiting lists were very long. Further, McGarry House residents' GPs were reluctant or refused to deliver outpatient detox because of overdose risk, risk of prescription abuse, and lack of adequate supports.

The management of Novas Initiatives proposed to create a funded, 60 hour per week service in which a community detox team would work with homeless clients toward their detoxification goals. In fact, the Novas CD site proved to be the only funded community detox programme in the national pilot programme; all other pilot sites relied on voluntary hours contributed from existing resources. The idea was to deliver a service focused on homeless services users (whether or not they received services from Novas Initiatives). Novas management aimed to deliver the Progression Routes protocols within an interagency approach. More specifically, the Novas Initiatives CD team would link with GPs, other drugs services, and with voluntary and statutory bodies such as child welfare, probation services, and community welfare officers. The team would complete intake assessments, evaluations, and care planning. They would also provide holistic treatments such as cognitive behavioural therapy, motivational interviewing, relapse prevention, and anxiety management. Through interagency collaboration, the team would link clients to other resources in the community to aid relapse prevention, including job skills training, life skills training, resettlement, and recreation.

The Novas Community Detox Team began enrolling service users in 2012. Early on it became apparent that the target population, residents of McGarry House and clients of other homeless services did not meet the eligibility criteria as outlined in the Progression Routes protocols, but that there was a great need for community-based benzodiazepine detox services in the broader area covered by the Midwest Regional Drugs Task Force. The team broadened the scope of its target population and increased its efforts to mobilize referrals beyond the homeless population. As a consequence, Novas Initiatives' management created additional pathways to serve the homeless population's substance misuse needs by enhancing the role of the dual diagnosis worker in McGarry House, who also became a member of the Novas CD team.

Novas Initiatives' management sought an independent local programme evaluation to assess the fidelity and outcomes of their community detox programme. Findings from this evaluation are presented and explained in this report. In the following chapters, the reader will find a description of the methodology used to collect data for this evaluation (Chapter 3); a fidelity assessment (Chapter 4); client outcomes (Chapter 5); and key features and qualities of service delivery (Chapter 6). Chapter 7, the final chapter, outlines the key findings and recommendations for programme development.

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METHODOLOGY

02

Methodology

There were five objectives for this evaluation: 1) to collect evidence for the fidelity of the Novas Community Detox to the original Progression Routes Protocols; 2) to describe the population of clients served by the Novas CD programme; 3) to assess the delivery of the programme; 4) to assess the outcomes and impact of the programme; and 5) draw conclusions for sustainment and development of the programme. The evaluation design was mixed methods. This means that qualitative data and quantitative data were combined in data analysis intended to achieve the five evaluation objectives.

Data Collection and Analysis

The data collected and analysed to compile this report were obtained from the following sources:

CLIENT CASE NOTES

It was agreed with the CD Coordinator that the six months leading up to the beginning of the evaluation period would be included in the case note review. Thirty client records were included in this sample. These case records included information about each phase of the detox process and included the team's approach to engagement, preparation, detox, disengagement, and aftercare. Using the Detox Protocols as a guide, the following assessment rubric was developed and used to document the contents of each case note file:

TABLE 1. CASE NOTE REVIEW

DIMENSION	EXPECTED DOCUMENTATION
CASE NOTE CHARACTERISTICS	• Status (closed or open case) • Number of case note entries • Included and completed forms: TOP; ICF; Record of disengagement
TEAM ACTIVITIES AND SUPPORTS WITH CLIENTS	• Evidence of interagency care planning • Evidence of working with client to build skills and knowledge about drug use, risk, and relapse • Medical supports – documentation of regular medical visits • Evidence of evaluation of suitability • Evidence of meeting detox entry requirements
BROKERING STAGE	• Referral to programme • Contact with physician • Explanation of the programme to client and keyworker where relevant – protocols shared, contact information shared • Risk information and agreement • Suggested next steps • Completed Initial Referral Form
PREPARATION STAGE	• Discussion of risk associated with withdrawal, seizures and overdose • Entry criteria • Evidence of relapse prevention and care planning – minimum of one hour per week • Evidence of addressing barriers to detox with client • Drug diaries • Sharing of drug diaries and care plan with physician • Completed TOP form
DETOX STAGE	• Commencement of detox • Evidence of client adherence (or not) with detox plan • Evidence of weekly meetings with client, topic of meetings, and next plans • Missed appointments • Evidence of timeframe prescribed by GP
AFTERCARE STAGE	• Evidence of weekly meetings • Evidence of working with client to prevent relapse and promote recovery
DISENGAGEMENT STAGE	• Note of client disengagement behaviours • Meetings missed & KW follow up • Evidence of topping up and response to this • Efforts to contact client • Disengagement form

QUANTITATIVE DATA

All available quantitative data from client records were coded and entered into an SPSS data file. Statistical analyses were then run on inputted data. Findings are presented in Chapter 5. See the Appendix for a full list of available quantitative data.

QUALITATIVE INTERVIEWS

Qualitative interviews were conducted in person and digitally recorded when possible. When not possible, phone interviews were conducted and notes taken during and after the interview. Each recorded interview was transcribed verbatim. These interview data were used as the basis of findings presented in Chapters 4 and 6.

Individual client Interviews: The evaluator requested a list of clients with a range of types of engagement with the programme, ranging from disengagement during the engagement period to disengagement after full completion of the programme. A list of 21 names was provided by the team to the Evaluator, who then contacted a selection of these individuals by text and by phone. Eight clients were interviewed, 5 in person and 3 by phone. Three interviewees were men and five were women. Semi-structured interviews were constructed in consultation with the CD Coordinator. The interview guide is included the Appendix.

Individual GP Interviews: The evaluator requested a list of GPs with varying degrees of engagement with Novas CD. A list of 16 GPs with their contact details was provided by the Novas CD team. The evaluator attempted to arrange in-person interviews, which where digitally recorded and transcribed verbatim. When face-to-face interviews were not possible, phone interviews were conducted. It proved to be difficult to recruit many GPs to interviews, partly because of timing and partly because their schedules did not allow time for this activity. Interviews were eventually completed with five GPs, three by phone and two face-to-face. A semi-structured interview guide was created in consultation with the CD Coordinator.

Key stakeholder interviews: The CD Coordinator provided the Evaluator with a list of 7 Key Stakeholders to interview for this evaluation. Five of these seven Key Stakeholders were interviewed. One Key Stakeholder was on annual leave an unavailable for interview. Another Key Stakeholder expressed interest in contributing to the evaluation but the evaluator was not able to secure the interview.

*Team member interviews***:** All three team members were interviewed on at least two occasions. These interviews focused primarily on the delivery of the programme at each stage of the protocol, adherence to the protocols, relationships with clients, relationships with one another, workload, responsibilities, development ambitions, challenges, and constraints to delivering the programme. The CD Coordinator was interviewed individually, and the two team members were interviewed together.

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Ethical Concerns

Standard protocols for ethical treatment of human participants were followed for every aspect of data collection. All participants were given information about the purpose and nature of the interview questions. All participants were assured that the evaluator would protect their confidentiality to that confidentiality is possible given the nature of this evaluation. Because the interviewees make up a small sample of a small community, it is possible that a reader of this report could draw some conclusion about the identity of some of the interviewees, and this limitation was communicated to each interviewee. The final draft has been approved by Key Informants who, by dint of their role, could potentially be identified by the information they provided. No identifying information about any client was included in the SPSS data file or in any of the case notes documentation. All identifying information is protected and will be deleted/destroyed when the final version of this report is agreed.

Limitations

As with any evaluation, there are some limitations to the data collected, and readers should keep these limitations in mind when assessing the findings. First, at the time of the evaluation, the team was in the midst of transferring over case notes from a paper-based to a computer-based system. As a consequence, only the paper case notes, and not the electronic case notes, were accessed for review.

Second, because this is a select sample of individuals who opted into the evaluation, the findings may not be representative of all clients, all GPs, or all Key Stakeholders. Third, the design of this evaluation, which does not include any type of pre-implementation assessment, means that it is not possible to draw conclusions about cause-effect relationships between the implementation of the service and key outcomes. However, because the evaluator was able to draw on multiple sources of data from a wide range of individuals involved in the project with different capacities, interests, and agendas, we can have confidence in the snapshot image of Novas CD that emerged from the analysis findings. A number of consistencies emerged across the quantitative data, the case notes review, and interviews with team members, GPs, key stakeholders and clients, and are described in this report.

Overview of Subsequent Chapters

The findings from quantitative and qualitative analyses are organized into three chapters. Chapter 4 presents the results of a fidelity assessment in which information about the delivery of the programme from clients, Key Stakeholders, GPs, and the team are used to gauge the extent to which the program evidences fidelity to the original Progression Routes Protocols. Chapter 5 includes a description of the Novas client population and their engagement with the services. Chapter 6 presents findings about the overall experience, effectiveness, and efficacy of the programme as described by clients, team members, key stakeholders, and GPs. The report concludes with Chapter 7, which includes a summary of key findings and recommendations for development planning.

FIDELITY EVALUATION

03

Fidelity Evaluation

"Model fidelity" refers to the extent to which a given programme adheres to an intervention protocol. In this case, we aimed to assess Novas Community Detox's fidelity to the Progression Routes Community Detoxification Protocols. Fidelity assessments identify the ways in which a model is adapted, modified, expanded, and enlarged. Some adaptations strengthen and enhance the delivery of a programme, and it is important to be able to identify key improvements and advancements made through model adaptation. "Model drift" refers to "the unplanned, gradual altering of an intervention" (Hagermoser, Sanetti & Kratochwill, 2009, p. 452). Model drift can lead to "model dilution", which occurs when a protocol is "watered down" on some key aspects so that the programme is not delivered at its full strength, or does not reach its intended population.

Team Roles, Responsibilities, and Competencies

In the Community Detox Protocols, there are three key roles: Broker, Key Worker, and Doctor. At its inception, these three roles were clearly delineated in the Novas CD programme. Soon after the programme was initiated, however, the broker and key worker roles were expanded and adapted in several important ways. In this section I describe how these roles are currently performed by the team members, the extent to which they adhere to the original model, and draw conclusions about adaptations for programme outcomes.

BROKER ROLE

This section reviews the fidelity of the Novas Community Detox Broker Role to the description of the role in Appendix B of the Progression Points Community Detox Protocol. In the original protocol, a very limited time commitment of one hour per week was allocated to the broker role, although it is defined by a wide range of time consuming tasks and responsibilities that would seem, in practice, to require much more than one hour per week. The broker responsibilities as outlined in the protocols include: 1) being the first point of contact for community detox in the local area and region, 2) promoting the Community Detox in the local area or region, 3) supporting the doctors and key workers to work under the protocols, 4) responding to inter-agency challenges as these arise, and 4) participating in the evaluation of the national pilot.

First Point of Contact. The person who is responsible for the broker role is the CD Coordinator, and the CD Coordinator effectively shares responsibility with the team members for being the first point of contact in the region for client referrals. The broker/CD Coordinator serves as the first point of contact for other drugs services in the region, other voluntary and statutory bodies, and for the key stakeholders who support the team and work with the team to provide interagency support. The broker/CD Coordinator is responsive to interagency concerns.

Programme Promotion. Interviews with doctors, team members, key stakeholders, and the broker/CD Coordinator indicate that the broker/CD Coordinator has successfully promoted the Community Detox in the region. Doctors in the region are familiar with the programme, as evidenced by case note review, the number doctors in the region who refer to the programme, and by interviews with local key stakeholders from other drugs services. Case notes showed that 64 doctors were named as clients' primary GPs. Three of these doctors were named by six to eight clients, five doctors were named by either four or five clients, 14 GPs were named by two or three clients, and 42 GPs were named by only one client.

In many ways, the broker/CD Coordinator has accomplished the work raising the profile of the community detox, in that the Novas CD is well-connected to the other voluntary and statutory bodies in the region. This visibility is sustained and strengthened through the team's collective work of giving presentations about the service, such as at residential facilities and to the local GP continuing education group. The broker and team explained that every six months or so they replenish promotional materials like flyers and pamphlets in public locations, such as doctors' offices and other drugs services. The visibility of these materials was confirmed in interviews with key stakeholders. Further, visibility is ensured through their continued outreach to more doctors in the region and their weekly presence at the LDAS, in North Tipperary, and County Clare.

Support to Doctors and Keyworkers. Interviews with team members and doctors, along with case notes reviews demonstrated the many and varied ways in which the broker supports doctors and key workers to work under the protocols. Interviews with doctors revealed that doctors' impressions of the broker/CD Coordinator are that of a highly competent, reliable, and professional expert in the field of addictions and recovery. The broker/CD Coordinator works with the other team members throughout all phases of the programme, including the engagement phase, in which assessment and information are delivered to the client; doctors are contacted to request their supervision of client's detox; and supervision, advice, and guidance are provided to both doctors and key workers. Interviews with doctors indicated that the doctors value the broker/CD Coordinator's expertise in delivering the protocols. Finally, because the broker/CD Coordinator and team key workers work so closely together, supervision is on an ongoing basis rather than on the six-weekly basis that is recommended in the Community Detox Protocols.

Respond to inter-agency challenges. In the course of this evaluation, little evidence was uncovered of inter-agency challenges. According to interviews with key stakeholders, the broker and the team

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have successfully managed to establish the programme as an important component of the continuum of care in the region, and the programme works cohesively and with complementarity to other key services in the region, such as Ana Liffey and the LDAS. The programme appears to work harmoniously with other bodies such as the Gardaí, probation services, and child welfare, which, in turn, facilitates care planning and relapse prevention for clients.

The broker/CD Coordinator organizes regular steering group meetings. The Novas Community Detox Steering Committee was created in the early days of the programme. Quarterly meetings are held and the membership consists of referring bodies and local stakeholders who can advise on important programming issues and challenges that arise in the effective delivery of community detox within this particular context.

Participate in the national pilot evaluation. The broker/CD Coordinator did participate in the evaluation of the national community detox pilot, but their site was not included in the final report, which has not been made publicly available and was not made available to this evaluator to review and compare outcomes. The broker/CD Coordinator reported that he made available a great deal of data to the national evaluators, and a good deal of the team's time was given to providing interviews to the national evaluators. Because no report has been published, and it is the broker/CD Coordinator's understanding that the Novas programme will not be included in that report; therefore, management chose to undertake the current evaluation.

In summary, the broker role was adapted and expanded in the Novas Community Detox Programme. The one hour per week allotted in the protocols is a twenty hour a week position, and the broker serves as a manager (CD Coordinator) for the Novas Community Detox team and for the Respite Service. The manager is responsible for the brokering tasks that remain in the adapted configuration, but extend to governance and oversight, team management, and liaison with the parent organization, Novas Initiatives. In addition, the CD Coordinator serves as a key worker, contributes to weekly drop-in hours, and works directly with clients. Interviews with team members indicate that the CD Coordinator carries out both the duties of a team member and the CD Coordinator to deliver the protocols with a high degree of fidelity and clinical oversight. He provides effective clinical supervision to team members and supports the team in their work to effectively provide care planning and relapse prevention supports to clients in their delivery of all stages of the programme.

KEYWORKER ROLE

This section assesses Novas Community Detox's fidelity to Keyworker Role as outlined in the Progression Routes Community Detox Protocol. One of Novas' adaptations to the original protocol is the development and expansion of its own community detox team to include in-house keyworkers. Early

attempts to arrange service level agreements with other social service agencies did not yield a significant uptake, and so the CD Coordinator has ceased efforts to broker key workers from other services. External key worker services were often reluctant to take on the key working role in community detox for a variety of reasons including their already stretched staff, and importantly, their unfamiliarity with and lack of training in drug and alcohol supports.

Although the Novas Community Detox Programme continues to utilize the services of keyworkers employed by other agencies through *Community Detox Participation Agreements*, virtually all keyworking is delivered by the Community Detox Programme Team. These team members, including the CD Coordinator, carry out all the tasks listed in the keyworker role description in the detox protocols. This is an important adaptation that enhances the delivery and reach of the community detox programme, and one which, according to key stakeholders, has established the Novas Community Detox as an important resource for drug treatment in the Midwest Region.

Key workers complete assessments with all new clients. Assessments may occur at the weekly drop-in hours that the team holds at the Limerick Drug and Alcohol Service's offices, in their own suite of offices at McGarry house, or any other location of the client's choosing. This includes a risk assessment with each client, a discussion of the risks associated with detox, and an explanation and overview of the Novas CD programme. These assessments include completion of all forms included in the Community Detox Protocols.

Key workers develop an individually tailored, client-led care plan, and review these plans regularly in team meetings. The keyworking team works together to develop and deliver a holistic care plan for the client that addresses her or his specific support needs. This often includes working with families to re-establish family supports. It also often includes linking the client to other services, especially housing services, medical services, and social welfare services. In many cases, other services are not equipped to deal with a client's co-occurring issues, and so the team will support the client on a particular need until she or he qualifies for other needed services, such as bereavement counselling. At this point, the team advocates on the client's behalf to link into the needed service.

Key workers offer clients some in-house services beyond weekly meetings, including acupuncture, meditation, and yoga. By offering these services, the team is able to introduce clients to new, more adaptive means to cope with stress and anxiety, which they can use in place of benzodiazepines. These services are a core component of the team's holistic approach to relapse prevention. The team's plans to expand their service to incorporate more resources for clients are described in Chapter 7.

Interviews with team members, doctors, clients, and key stakeholders indicate that the team meets and exceeds the minimal standards for the delivery of community detox as outlined in the Community Detox Protocols. For example, team members described the range of interagency supports with which they link eligible clients, their advocacy on behalf of clients with voluntary bodies like housing services, with statutory bodies such as child protection and probation services, intensive engagement with family members, and their efforts to support clients in re-engaging with, or initiating new occupational interests whether educational, occupational, social, or wellness-related. Fully integrated into these activities are efforts toward relapse prevention.

Relationship building is a key ingredient in this team's approach. Team members prioritize the development of a strong foundation of mutual trust between the team and client, so that clients can fully, and without fear of judgment, discuss their drug use histories, personal stories of trauma, abuse, or other experiences that precipitated their drug misuse. In doing so, team members are able to work intimately with clients to gain insight into and knowledge about their drug misuse and to develop clients' own personal capabilities around relapse prevention. Relationship building with doctors is also an important aspect of the keyworker role. Key workers actively cultivate and maintain strong lines of communication with doctors and in most cases attend regular doctor appointments with clients. Interviews with doctors, team members, and clients clearly indicate that channels of communication are open amongst all parties involved in a client's detox.

Client Eligibility and Intake

One important aspect of model fidelity is whether a programme reaches its intended client group. Review of case notes and referral documentation, and interviews with team members indicate that almost all individuals who approach or are referred to the detox programme meet the criteria for a benzodiazepine detox. For several reasons, including ineligibility due to high daily dosages and barriers to access caused by long waiting lists, these individuals cannot gain access to residential in-patient treatment. The Novas Community Detox programme fills this gap in service availability for a cohort of individuals in the region who badly need medical detox from benzodiazepines.

Based on available data, it is difficult to pinpoint how many referred individuals do not meet the eligibility criteria as outlined in the Community Detox protocols. The team has broadened the definition of an eligible referral, is willing to take on, and has taken on, individuals whose usage falls outside that which is described in the protocols. Further, the team works with clients with complex dual diagnosis and dual addiction needs, although they sometimes face challenges linking with a doctor who is willing to detox someone with active poly-substance use or active psychiatric symptoms. As a consequence, the clients with whom the team works often have multiple and complex support needs and does not refuse services to individuals who might be labelled "difficult-to-serve".

Phases of Community Detox: Engagement, Preparation, Detox, and Aftercare

ENGAGEMENT

In the engagement phase, which in the Progression Routes Community Detox Protocols is called the Brokering Phase, service users are referred to the programme, team members complete the initial assessment, and all forms included in the Community Detox Protocols. The responsibilities of the broker at the engagement phase have been absorbed into the CD Coordinator and team member roles. Instead of brokering the keyworker role, Novas CD staff assumes the keyworker role. The team does continue to work with a few other services in the manner outlined in the Community Detox protocols, but efforts toward cultivating these relationships have been discontinued. This adaptation is discussed in more detail in the final section of this chapter. It is a key adaptation that goes beyond the protocols in important ways, and which evidence indicates improves delivery, staff outcomes, and client outcomes.

Engagement may be **initiated** by a service user, a doctor, or another voluntary or statutory organization. Novas CD operates weekly drop-in hours at the LDAS, where service users can meet with team members and explore the possibility of community detox. These drop-in hours are an important and heavily used entry point to the community detox programme. The team also accepts referrals from anyone – from doctors, from other drug services, from statutory bodies, and self-referrals.

Regardless of the entry pathway, in the engagement phase the client engages with the team and the team describes the service to the client. During this phase the team explains the risks and benefits of detox to the client, explains the drug diaries and the subsequent phases of the programme, and helps the client begin to complete the drug diaries. For clients whose entry point is through LDAS drop-in hours, the engagement phase ends when the team invites the client to begin meeting in regularly scheduled appointment hours in McGarry House rather than in LDAS. For clients with more complex support needs, this shift signals

that the team has a deepened level of confidence in the client's commitment to detox that seems, in turn, to reinforce the client's commitment to the detox enterprise. At this point, the client and team are ready to commence the preparation phase. The team member who is the primary link to the client ensures that the doctor, the team, and the client have shared information and mutual understanding of the client's detox goals.

PREPARATION

According to the protocols, the service user and key worker begin key working sessions prior to the beginning of dose reduction. This is to support the service user to meet entry criteria by establishing or reviewing the care plan and to begin relapse prevention work.

Clients meet on a minimum of four occasions with a Novas Community Detox keyworker and during this time the team takes a holistic approach to care planning. Interviews with team members indicate that these meetings are individually-tailored and client-led. The team pays keen attention to the client's social and psychological needs and strengths, within her or his local context. Clients are linked to other local services that can meet their support needs such as housing or social welfare payments. Keyworkers work with clients' families to repair and strengthen relationships, and they work individually with clients to develop clients' self-confidence and the personal resources they need to sustain the detox.

Interviews with the team indicate that they place a great deal of importance on establishing the client-keyworker relationship during the preparation phase. "Meeting them where they are at" is a core principle for this team. This client-led, consumer choice-driven approach appears to be one of the key ingredients of the success of this team in encouraging and empowering clients toward a successful detox. Through this approach the team is able to cultivate the client's trust and confidence that with the team's support, she or he can sustain a detox. Interviews with both staff and clients indicate that the team works with clients at the clients' own paces toward meeting the entry requirements for detox, regardless of how long and slow this work may be. The team continues to engage with clients in an open-ended time frame, led by client interest and motivation, until the client is ready to move to the detox phase.

Interviews with team members revealed the importance of the preparation period to relationship building. The preparation period is used to learn about clients' use patterns, their life histories, and in that, the causes that underpin their current overreliance on benzodiazepines. Importantly, interviews with clients revealed how they experience these weekly meetings – uniformly – as "having a chat", as a private space in which they can talk about what is going on in their lives, their problems, and their substance misuse, with full acceptance and without fear of judgment or reprisal. Clients frequently explained how important it was that they felt that they could tell the team members anything and everything about their lives. Clients felt, through the team member's actions, that the team was committed to them and their recovery. This feeling, of another person's commitment to one's own well-being, seems a vital aspect of the process through which this programme is delivered, and it carries through the detox and aftercare phases.

Although the doctor may have referred the client, the doctor's role in the preparation phase is minimal, and limited to medical services. Interviews with doctors and Novas staff indicate that Novas staff only initiates contact with the GP about beginning the detox phase when a client meets the entry dose level criterion and the team has confidence in the client's commitment to medical detox. A high level of transparency and open communication characterizes the relationship of team members to prescribing doctors. Key workers attend visits to doctors with clients on a regular basis. Indeed, interviews with staff, doctors, and clients indicate it is the rare occasion that a key worker does not attend the GP visit with the client. Information is shared in these meetings, which are led by the GP – client relationship.

The Progression Routes Protocols require clients to provide a minimum of 14 consecutive days of drug diaries for the period leading up to the initiation of detox. In the Novas Community Detox, the drug diaries are integrated into the preparation phase, and are seen by the team as an important resource for really getting to know and understand the client and her or his needs. Clients and staff report that drug diaries usually extend substantially beyond 14 days. In interviews, staff members frequently referred to diary periods extending from four weeks to two or more months prior to the initial appointment with the GP. This elongated diary period ensures that the service user's benzo use tapers at a rate that minimizes the risk of relapse, maximizes the client's comfort with tapering, and builds the client's confidence that she or he has the capability to successfully taper and ultimately completely detox.

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Longer and slower preparation phases seem to foster team members' confidence in clients' commitment to detox. Importantly, it also facilitates the team's familiarity with the client and the client's familiarity with the team.

During the preparation phase a client meets a key worker for a minimum of an hour a week to review the drug diaries, and explore their support needs. Interagency care planning includes social services and family supports and structures that will support the client's individual efforts toward tapering and relapse prevention. Each support plan is individualized to a particular client's own resources and needs. The team explores the ecology, or context, of each client's life and works to identify and re-establish positive supports. In interviews, both clients and staff described how the key workers work with the whole family where possible to strengthen supports that will support the client and prevent relapse. The team works holistically with clients during this period to link in with medical cards, social welfare, and other drugs supports such as NA. Many clients are at risk of homelessness, and the team works with them to obtain housing. The Novas CD team also refers clients' families to the Respite House.

Importantly, the team works with clients at their pace and driven by client interests to replace benzodiazepines with other stress-reduction and coping resources like meditation and yoga. Recently the team has been able to put weekly classes in place at McGarry House, and clients avail of them. Clients are also linked into a local gym, and are encouraged to try out or resume activities that may help them deal with stress and cope with anxiety through other channels and build their capacity to do so while at the same time they reduce their benzodiazepine consumption. The respite house is availed of by client's families, and this often helps reduce tensions and allow family members to come back together again. Respite House is a brief intervention for families of alcohol and drug misusers. At Respite House, expert members of staff provide psychosocial skills development (e.g., parenting, boundary setting), and complementary therapies (e.g., reflexology, massage and acupuncture). Respite House is a peaceful and therapeutic environment where family members may recover from the stresses of a loved one's alcohol or drug misuse, and also learn new ways of coping with these stressors.

The Novas CD team modulates the pace of the preparation phase to fit the needs of each client. The preparation phase may be as short as four weeks, but as long as six months. As long as a client engages with the team, the team engages with the client. The preparation phase continues for as long as necessary, with no time limit, until the client reaches a level of benzodiazepine use that meets the detox entry criteria. Once the client has achieved the entry criteria, contact with the GP is initiated. The team has established relationships with many GPs in the region; most GPs who serve this population are aware by now of the community detox. If a client's GP has no prior experience with Novas CD, then the CD Coordinator introduces the project to the GP, explains the service, and provides

them with copies of the protocols and other relevant information. Often, however, at this stage, the GP is already familiar with the programme, and so the groundwork is already laid. If the client was referred by her or his GP, the team contacts that GP to share information about the client's work during the preparation phase and their current benzo intake. In circumstances where the client may not have a GP, then the team works with the client during the preparation phase find a GP and begin to link in to her or his surgery.

DETOXIFICATION

According to the Community Detox Protocols, this stage involves the service user reducing medication in line with a schedule agreed with the doctor. The key worker continues to provide care planning support and relapse prevention throughout the detoxification period.

Interviews with doctors, clients, and team members indicate that the team effectively provides supports to both doctors and clients during this phase. Clients and team members described how the team members usually to always accompanies clients to their doctor visits on a weekly basis. Clients meet with their doctors regularly, at minimum every two weeks, but often on a weekly basis. In line with Progression Routes Protocols, daily dispensing is adhered to in the beginning phase of a detox, but as the client progresses, less frequent dispensing is regularly negotiated and agreed amongst the doctor, client, and team.

The detox schedule is determined by the doctor in collaboration with the key worker and client. Team members report that doctors are often receptive to information provided to them in the protocols and from the team regarding the development of a client's detox schedule. However, the extent to which the doctor is willing to negotiate the detox schedule with the client and modify the schedule in response to the client's comfort level is variable. Clients and key workers described some experiences with doctors who rigidly apply a detox schedule from beginning to end, while other doctors work with the client to modulate the pace according to client comfort. From client and team member interviews, it appears that the degree to which the doctor attunes to a client's comfort has an effect on the client's experience of the detox. Interviews with clients indicate that they respond better to longer detox schedules than shorter detox schedules. Clients' descriptions of their detox experiences indicated less satisfaction with doctors who adhered to a rigid schedule of detox than with doctors who were willing to lengthen the detox period and modulate the pace in response to clients' comfort.

During the detox phase, in line with Progression Routes Protocols, an additional weekly meeting occurs between client and key worker for care planning support and relapse prevention. These weekly client-key worker meetings sometimes increase in frequency in response to client support needs. Interviews with team members and clients illustrated the ways in which the team modulates the intensity and frequency of supports in response to client needs and interests. For example, during stressful life events or transitions, the team members intensify supports provided to clients. As a consequence, clients report a high degree of confidence that the team is "always there for them" and can be called on at any time. The feeling of security and dependability that clients describe and that team members deliberately cultivate seems to be a key ingredient in clients' successful detox and the prevention of relapse.

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The team is highly committed to supporting clients through the detox phase and will continue to support the client through periods of missed appointments, relapses, and challenging behaviours. However, the team also adheres closely to the Progression Routes Protocol guidelines concerning missed appointments. Key workers attempt to reengage clients who miss appointments without cancelling and rescheduling, but those who miss two or more appointments without reason and without rescheduling are discharged from the programme. Case notes and interviews with team members indicate that the team communicates to clients that the door to reengagement is always open to them when they are ready to try detox again. Case file review, interviews with team members and with clients indicate that clients do, in fact, return to the team and try again.

AFTERCARE

According to the protocols, the key worker and service user continue to engage in weekly care planning and relapse prevention supports for six months following completion of the detox. Interviews with team members and clients indicate that all clients receive a minimum of six months aftercare planning and relapse prevention supports. This phase is open-ended, so that clients who need a longer aftercare phase will receive it, and those who need to return to aftercare for additional support may do so. The team members talked about the importance of building personal, interpersonal, and community supports during preparation and detox phases so that when the client reaches the aftercare phase, the detox programme can become a smaller and smaller part of an increasingly dynamic community within which the client is integrated. The creation of a "wheel of supports" (see chapter 6) is an important aspect of this team's approach to support planning. According to the team, if the work is done during the preparation and detox phases, then then other supports take over from Novas, so that both Novas and the person's drug misuse, can fade into the background and become a minor aspect of the client's life and identity.

In interviews, clients talked about the aftercare phase as an important incentive to completing the detox phase. Clients who were interviewed for this evaluation expressed how much they valued the team's continued support. One client in particular, who was in the detox phase at the time of interview, repeatedly referred to aftercare as a valued component of the programme, and the she looked forward to reaching that phase of the programme.

DISENGAGEMENT

According to the Progression Routes Community Detox Protocols, disengagement refers to the point in time when a service user ceases to engage with the team. Disengagement occurs when clients miss two or more meetings with the key worker or if the client is believed by either the doctor or the key worker to be misusing substances during the detoxification period.

Interviews with team members, clients, and doctors indicate that the team closely follows the Progression Routes protocol guidelines for disengagement. The team does not impose any additional requirements on clients that result in disengagement for reasons other than those stated in the protocols. Interviews with clients indicate that they understand that these are the only conditions under which the team will initiate disengagement. Clients expressed a great deal of trust in the team, in that they have the confidence that they can share any substance-related or – unrelated problem, such as legal, social, medical, or psychological with the team and the team will not remove or restrict any of the programme services. This level of trust and transparency between client and team appears to be a vital aspect of both support planning and relapse prevention, one that is mutually highly valued by both the team members and the clients.

Case notes review, interviews with team members, clients, and doctors indicate that when disengagement occurs, it is typically when clients' miss appointments without reason or reschedule. Occasionally, clients engage in drug misuse that triggers disengagement, but the team, and sometimes the doctors, are willing to tolerate relapses and polysubstance use when clients are committed but struggling. Open lines of communication between doctor and key worker, and between key worker and client, facilitate attempts to address the client's behaviours and avoid disengagement. In some cases, however, the client's behaviour warrants a discontinuation of the detox phase. When this occurs, the team communicates an open-door policy to the client so that the client may re-engage when she or he is ready to try another detox.

Conclusion

According to the Community Detox Protocols, the minimal standards for delivery community detox are:

- Interagency care planning: support planning that takes into account all factors that may negatively impact on ability to engage in a successful detox such as housing, family matters, meaningful use of time and social supports;
- Relapse prevention: structured sessions aimed to provide clients with skills and knowledge base around drug use, risk, and relapse;
- Medical supports: regular medical appointments. Doctor agrees to engage in interagency communication with the key worker about client progress and changes to initial detox schedule or care plan.

The findings from this fidelity evaluation indicate that the Novas delivers community detox with a high degree of fidelity to the Progression Routes Protocols and certainly meets and exceeds the minimal standards outlined above. The team and its management have made a number of important adaptations to the delivery of the protocols, which seem to have improved the model and strengthened its delivery. Some of the key adaptations that appear to have contributed to the successes of this programme are:

1. Expansion of the role of the broker in terms of hours and responsibilities;
2. Development of a highly skilled, highly competent team of keyworkers who support clients and doctors in the delivery of the community detox protocols;
3. Focus on in-house keyworker support to clients and doctors rather than service agreements with other regional agencies;
4. Systematic and strategic development of in-house resources for clients to avail and support their preparation for detox and for relapse prevention such as acupressure, meditation, and yoga.

Taken together, these adaptations clearly appear to have contributed to the programme's reach and intensity. There is no evidence from case note review, from interviews with stakeholders, team members, clients, or doctors that the Novas implementation of the Progression Routes community detox protocols has in any way drifted away from the fundamental intention to create opportunities for individuals in the Midwest Region to avail of community-based detox. In fact, the adaptations observed in this programme only strengthen the model and enhance the team's ability to provide clients with supports from highly qualified experts in addiction and recovery while they undertake supervised medical detox in their own communities. In the following chapters, evidence for key outcomes of the programme are presented.

REFERENCES

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CLIENT DESCRIPTIONS & CLIENT OUTCOMES

04

Client Descriptions & Client Outcomes

The team recorded a total of 335 contacts between 1 May 2012 and 24 June 2015. From these contacts, 132 new cases were opened. Of these cases, 73 (55.7%) were still open, while 58 (44.3%) had disengaged from the programme at the time the data were obtained (26 August, 2015).[1] The following client information was obtained from analysis of these 132 unique cases.

Client locations were spread across the Midwest region. Most were located in Limerick City (*n* = 59, 45.4%) or Limerick County (*n* = 33, 25.4%), but a notable number were located in County Clare (*n* = 18, 13.6%) and North Tipperary (*n* = 19, 14.6%). Referrals came from a number of sources: self-referral (19.5%), LDAS (15.8%), or GP (12.0%). Answers to the question "how did you hear about the service?" were recorded for 26 clients. Sixty percent of these 26 clients reported they heard about Novas CD from either their GP or another drug service.

Data on duration of engagement with Novas CD was available for 127 clients. For these 127 clients, the average length of engagement with the programme was 38.5 weeks, with a range from 1 week to 3.25 years. For engaged clients (*n* = 57), the average length of contact was 41.34 weeks (9 months), with a range from 3.86 weeks to 3.25 years. For disengaged clients (*n* = 69), the average length of engagement was 36.37 weeks (8.37 months), with a range from 1 week to 2.14 years. Neither age, sex, nor whether or not the client had dependents predicted duration of contact.

Information on the phase of treatment in which disengagement occurred was available for 70 clients. Most (70.4%) clients disengaged during the preparation phase, while only 4.3% (3 clients) disengaged during brokering, and 5.7% (4 clients) disengaged during detox. One in ten (7 clients) disengaged when after care was completed, and another 8.6% (6 clients) disengaged during aftercare. This indicates that 18.5% of clients for whom we have complete data stayed engaged until they completed detox and at least some aftercare.

Further information about disengagement is available for 56 clients. Of these 56 clients who disengaged from services, 89% (47) disengaged

1 Numbers of participants do not always add up to 132 and percentages do not always add up to 100% because of missing data.

before detox started, and 9 disengaged after detox started. Of those who disengaged before detox started, 36% did not meet the criteria and did not want to begin detox; 32% met the criteria, but did not want to continue; and 30% met the criteria for detox but could not continue for other factors. Of the nine clients who discontinued after detox was initiated, only one availed of support but continued to use, 3 missed two or more appointments, and five disengaged for another reason. Most clients (92.7%) ceased contact with their keyworker after disengagement.

Average client age at first contact was 31.28, with a range from 18 to 65, and men and women were not different from one another in age at engagement. Eighty-one (61.4%) clients were male, and 51 (38.6%) were female. All clients except one were Irish citizens; the exception was from Poland. Information on education was not collected. Most participants were unemployed (*n* = 108, 81.8%), while only 8 (8.8%) were employed either part- or full-time. Almost half of clients (47%) had at least one kind of ongoing legal problem. The most common criminal justice issues were probation (12%) or pending charges (11%).

Although most clients were unemployed, only about 29% reported that they receive a social welfare payment. Females were more likely to report receiving a social welfare payment (29.4%) than males (17.3%) ($\chi^2 = 5.52$, $p = .019$). Most clients lived in the family home (*n* = 43, 31.6%) or rented or owned their own home (*n* = 35, 25.7%), with the rest lived either in Local Authority housing (13.2%), hostels (8.8%), or with friends or relatives (8.1%). About 10% of clients were at risk of eviction, and 18% had experienced an acute housing crisis in the past 30 days.

Most participants (61%) reported that they did have dependents. Women were more likely (78.3%) than men (55.3%) to say they had dependents to care for ($\chi^2 = 4.59$, $p = .03$). The total number of dependents each participant reported ranged from 0 to 9, with an average of 1.55 dependents per client. Men reported an average of 1.39 dependents, and women reported an average of 1.83 dependents, but the difference was not significant. The number of dependents under age 18 ranged from 0 to 7, with an average of 1.26 per client. Men reported an average of 1.04 dependents under 18 and women reported an average of 1.59 dependents; this difference was significant ($t = -1.99$, $p = .049$). Most participants (60.3%) were not single parents, and women were much more likely to report that they were a single parent ($\chi^2 = 20.64$, $p < .001$).

PHYSICAL HEALTH

Data on subjective physical health status were available for 84 clients. On a scale from 0 = *poor* to 20 = *good*, average client rating of physical health status was 9.53 (slightly below the midpoint), with a standard deviation of 5.20 and a range from 0 to 20.

PSYCHOLOGICAL AND PSYCHIATRIC INFORMATION

Of the 92 clients for whom we have data, 57.6% reported no history of psychiatric symptoms. The most frequently reported psychiatric problems besides anxiety were depressive symptoms: 26% of clients reported problems with unipolar depression or depression mixed with anxiety, and/or suicidal thoughts and/or suicide attempts. Other kinds of psychiatric problems such as psychotic disorders and bipolar disorder were reported at much lower rates.

Data on subjective psychological health status were available for 84 clients. Clients rated their psychological health on a scale from 0 = *poor* to 20 = *good*. The average score was 7.27, with a standard deviation of 4.18 and a range from 0 to 18. The sample average was significantly lower than the midpoint of the scale (10) ($t = -5.97$, $p < .0001$). Clients were also asked to rate their quality of life on the same 20 point scale. The average score was 8.37, with a standard deviation of 5.37 and a range from 0 to 20. The sample's average quality of life score was significantly lower than the scale midpoint (10) ($t = -2.73$, $p < .008$).

REPORTED DRUG PREFERENCES AND DRUG USE AT INITIAL CONTACT

Upon acceptance into the programme, clients are asked to rank order three drugs of choice and to report their current use rates. These are presented in Tables 2 and 3. As can be seen in Table 2, benzodiazepines were the large majority of clients' drug of choice, with 65.4% ranking them as their top preference, and 91.1% ranking them in the top three. Cannabis was listed in the top three by 28.6% of clients, and heroin was listed in the top three by 23.5% of clients. All other categories of drugs and alcohol were reported much less frequently.

TABLE 2. DRUG OF CHOICE

DRUG	1st PREFERENCE		2nd PREFERENCE		3rd PREFERENCE		TOTAL
	%	COUNT	%	COUNT	%	COUNT	%
BENZODIAZEPINES	65.4	89	22.8	31	2.9	4	91.1
ALCOHOL	3.4	5	8.8	12	4.4	6	16.6
CANNABIS	5.1	7	20.6	28	2.9	4	28.6
HEROIN	12.5	17	11.0	15	-	0	23.5
METHADONE	-	0	4.4	6	-	0	4.4
SLEEPING TABLETS	2.9	4	<1.0	1	<1.0	1	7.6
COCAINE	2.9	4	3.7	5	<1.0	1	7.6
AMPHETAMINES	<1.0	1	1.5	2	1.5	2	4.0
MORPHINE/ANALGESICS	2.2	3	1.0	< 1	<1.0	1	4.0

Clients are also asked to report current drug use type, amount, and frequency. As can be seen in Table 3, benzodiazepines are the most used drug by Novas CD clients. Novas Community Detox was the first drug treatment for 27% of clients. The other 75% of clients reported previously engaging in one or more drug treatment services. Previous engagement in methadone treatment, counselling, and Narcotics Anonymous were reported by 30% of clients. Sixteen percent had entered inpatient detox, and six percent had engaged in outpatient detox. Nine percent had engaged in needle exchange. Almost one-third (31%) of clients are also currently on methadone maintenance. Reported dosage ranged from 10 to 115 milligrams (average = 64, standard deviation = 28).

TABLE 3. DRUG USE AT INTAKE

BENZODIAZEPINES

	0 TO 5	6 TO 10	11+	DAILY	2 TO 6 DAYS PER WEEK	WEEKLY	MONTHLY
NUMBER OF CLIENTS	35	21	40	91	2	3	0
% PERCENT (OF 132)	26.5	15.9	30.30	68.94	1.5	2.27	0

ALCOHOL

	0-10 UNITS	11-20 UNITS	21 + UNITS	DAILY	2 TO 6 DAYS PER WEEK	WEEKLY	MONTHLY
NUMBER OF CLIENTS	2	3	4	4	6	2	0
% PERCENT (OF 132)	1.5	2.27	3.03	3.03	4.54	1.51	0

CANNABIS

	1-3 SPLIFFS	4-6 SPLIFFS	7-9 SPLIFFS	10+ SPLIFFS	DAILY		
NUMBER OF CLIENTS	5	5	4	3	17		
% PERCENT (OF 132)	3.78	3.78	3.03	2.27	12.88		

HEROIN

	<1 BAG	1-3 BAGS	4-6 BAGS	DAILY	2 TO 6 DAYS PER WEEK	WEEKLY	MONTHLY
NUMBER OF CLIENTS	3	10	1	10	1	4	2
% PERCENT (OF 132)	2.27	7.58	<1.0	7.58	<1.0	3.03	1.51

METHADONE

NUMBER OF CLIENTS	% PERCENT (OF 132)	MINIMUM	MAXIMUM	AVERAGE	STANDARD DEVIATION	DAILY
21	15.91	35	115	76.79	19.28	22

KEY FEATURES AND QUALITIES OF SERVICE DELIVERY

05

Key Features and Qualities of Service Delivery

Findings regarding the key features and quality of service delivery are described in this chapter. These findings were derived from transcripts and notes obtained from interviews with Key Informants: team members, service users, doctors, and key stakeholders. Findings are organized into eleven topics. In combination with the fidelity assessment and quantitative client outcomes, the findings presented in this chapter build toward the development plan and recommendations presented in the final chapter of this report.

General Appraisals of the Novas Community Detox Programme

All Key Informants indicated that they believe that the service is competently delivered to the intended population and that it is a needed service that fills an important gap in the continuum of care. Further, the service is appraised not only to adhere to the Progression Routes Protocols, but also to go beyond the Protocols in its implementation of a fully staffed team. Key Informants described the team as highly committed to delivering the protocols. For example, one Key Informant referred to the Novas programme as one of the few programmes included in the national pilot that was really committed to delivering community detox according to the protocols. Key Informants listed a number of ways in which the Novas CD Coordinator demonstrated this commitment, including: attendance at Dublin broker meetings, diligent engagement with the community, successful and broad engagement with services, doctors, and stakeholders. One Key Informant described Novas as seeing *"the value of the community detox programme, dedicating resources to it, and using the structure well. It was the gold standard for delivering community detox."*

Virtually all Key Informants described the team as passionate, skilled, and professional in

their interactions with key stakeholders, doctors, and clients. One Key Informant described it this way: *"Maybe it took a bit of time to get their name out there but then they did. They did that very well. I mean that in the broader context, I mean the strengths were getting in with the GPs and so on so quickly. Um, strengths are the personnel involved, strengths are their ethical approach, their community base, [and] good governance structure, [both] clinical and operational."*

Some Key Informants complimented the team on the extensive development and self-learning they have accomplished since initiating the programme. For example, one Key Informant said: *"Yeah I mean when, when the project started we were all finding our feet a little bit. Novas were trying it out, we weren't sure about this project, but as time has gone on we're almost learning as much from the project as- as anything, 'cause it's new, it's different, it's never been done before."*

Team Governance and Oversight

Key Informants' impressions of team management were very positive. The CD Coordinator was described as "*having a good handle on it in terms of his team and how it's running*, as having "*good ideas in terms of developing the project* [and] *at the same time making it sustainable….I have a lot of faith in Dan in his experience and so on. So that's what I'm saying about Novas employing the right people, um, and then in terms of reading from the reports, from a governance perspective the boxes seem to be ticked, and I know that Novas is very strong in that because of their own line of work anyway in the homeless area, so they adhere to the QuAds framework, they adhere broadly to the community detox framework, um and then they adhere to the criteria that's laid out in the Service Level Agreement, so from that perspective I don't see any issues, you know."*

ADHERENCE AND COMMITMENT TO PROTOCOLS

Although the team is appraised to have excellent governance and oversight, their approach to community detox varies in some important ways from the National Steering Group, and some Key Informants raised this distinction to illustrate how the team responds to oversight challenges arising from differences in approach to detox. Adaptations to the broker and key worker roles were questioned by some individuals involved in the National Steering Group who developed the protocols and had oversight of the national pilot. The fact that

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Key Informants from the national level of oversight praised the work done by the CD Coordinator in the blended broker-keyworker role indicates that the CD Coordinator effectively negotiates these differences in approach.

Novas' funders were happy with and supported these adaptations and expansions. In fact, Key Informants described these adaptations as some of the keys to the team's successes. Indeed, taken together, findings from this evaluation suggest that the adaptations to keyworker and broker roles enhance the delivery of community detox, and the Midwest Region's decision to fully fund a community detox and staff it beyond the minimal standards as laid out in the protocols was wise, showed foresight, creativity, and resourcefulness.

Relations with other Drug Services in the Region

Because drugs services need to work together to effectively deliver the full range of services represented in the continuum, it was important that Novas CD developed positive relations with other drug services in the region. The Novas CD is viewed by Key Informants as a vital step in the continuum of care in the Midwest Region. One Key Informant described Novas Community Detox as having a "*very important role, [a] hugely important role. … Community detox is probably their first port of call, as opposed to residential, 'cause a lot of the cohort that avail of low threshold service, they wouldn't be referring into residential largely speaking, they'd be [referring to] Coolmine, so community detox, so their relationship is key."*

One Key Informant who works in pre-treatment services for a rehab-only programme said that Novas CD runs a very good programme that provides an important complement to his service. This Key Informant values being able to refer clients to a detox programme where the workers follow effective protocols. This Key Informant observed that when doctors work alone they can detox their patients too quickly, and that Novas CD helps slow this process down. He said Novas CD also helps the clients understand that a slow detox is a better and more effective detox because it reduces risk and keeps the person engaged rather than get frustrated because they want a quick fix. This point is returned to in a later section of this chapter focused on the team's relationships with doctors.

Not only does Novas Community Detox have an important role in the delivery of drugs services in Limerick City, they also contribute to drugs services in the entire region. They contribute to drop-in services in County Clare and in North Tipperary. They are also a regular participant in Dromin House Day Hospital in their dual diagnosis treatment pilot, an aspect of the services they deliver which is described in a subsequent section of this chapter. Novas' contribution to regional drugs services is highly valued by key stakeholders who said it is "fantastic" that such a small service makes such a large contribution to this sprawling geographical region, which is difficult to cover and provide enough services to meet the needs of the region's residents.

However, early days were accompanied by a rocky start and some interagency challenges. For example, in the early days, Novas CD had to convince other treatment services to send referrals to them. Over time, however, Novas leadership worked out effective interagency relationships, and tensions dissipated. Now, it seems that Novas CD's place in the continuum of care is well-established and appraised to complement rehab and other types of inpatient or residential treatment.

Clinical Governance and Management

Key Informants appraised the Novas community detox to have a good governance structure and to have a range of competencies that are valuable in the delivery of community detox, all of which position this team as particularly qualified to operate this service in the Midwest. One Key Informant said: "*…homelessness was their [Novas'] priority but they really have branched and taken on board and developed that experience and they've got the right staff on board, the likes of Dan who has that expertise. I would have had concerns if it was a very much homeless-driven mentality within the service… but it's not. It's homelessness, drugs, early school leaving, bullying; you know, they're very au fait with the holistic approach, so that appeals to me: the fact that they're very community focused, the fact that they're working well with other services, the fact that they work well with ourselves."*

COST-EFFECTIVENESS AND COST-BENEFIT APPRAISALS

Key Informants with insight into financial aspects of the programme indicated that they believe the programme represents a good value for money. For example, when asked whether the Novas CD gave a good return on the investment, one interviewee said: *I [am] well-placed to answer that. [] I see the [] operational reports and [] financial breakdown [], and to be fair to Novas, and I'd say this for both their projects, respite as well, very much so, very much so.*

Not only do Key Informants report that the community detox yields an important return on the investment, their impression is that the programme is highly cost-effective, in that it is much less expensive than residential detox, yet still produces positive outcomes for service users and their communities. One Key Informant said: *"If we were to run a fully- fledged residential detox facility in the Midwest that would be our budget wiped, so that would be all the other projects: The community substance misuse team, Ana Liffey, the respite house with Novas, Clare Youth Service project, all these things would go because we'd have to put all our money into a detox facility. There was massive pressure from the community level four or five years ago and ourselves and the HSE to set up a detox facility um, hence the community detox protocols from Ana Liffey* [operated by Novas CD], *they were welcomed, it was an alternative, and it seems to be working quite well, and while I think it seems to work well and this is my opinion, from speaking to people is that it is community-based and it goes back to that piece of meeting people where they're at. Treatment services aren't for everyone [because] they're expensive, they've waiting lists et cetera. All these things are bypassed with the community detox approach."*

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Importantly, community detox is not only less expensive and more accessible to a wider population than residential detox, it also offers an approach to detox that has a particular set of advantages. Novas community detox offers the service user an opportunity to detox within the community, during which time they can develop supports and personal skills *in vivo* that will contribute to relapse prevention. As one Key Informant said, when a service user is *"off somewhere in a treatment centre where everything's rosy, everything is lovely, you're away from the world for four or five weeks, … and then you're [discharged], you're back you're back to the cycle - yeah back to the cycle of reality"*, without having necessarily learned the skills you need to deal with that reality.

TEAM COMPETENCIES AND TEAM FUNCTIONING

The team's community-based approach meshes well with Key Stakeholders' priorities for the delivery of drugs services in the Midwest Region. For example, one Key Informant said: *"projects like this [], the fact that they're in communities, they're listening to people on the ground, they're actually clued into what's going on- on the ground, that's what really appeals to me about this project you know []. I see it with my own two eyes, because the relationships they have, even in McGarry you know, because they're dealing with clients every day of the week, they know how to relate to [clients] … that's a major benefit for the community detox project that they have that hands-on everyday experience."*

Community Supports and System of Supports are Congruent with Funder Priorities

As described in Chapter 4, and as illustrated in the Client Outcomes section of this chapter, the team takes a family-centred approach to delivering the community detox programme. This approach is consistent with Key Stakeholders' visions for the delivery of drugs services in the Midwest region: *"Family is a big factor within our approach 'cause if you can get the family unit right, you get a lot of the other issues close to right, maybe not always, but family is a big factor. [] And to be fair, the community detox is now very much built in and bedded in, in that broader, that broader plan, you know."*

The team's efforts to build effective support structures in the community that reach beyond clients' families are also congruent with key stakeholders' priorities for drugs services in the region. One Key Informant said: *"support structure is key as well, so that when [clients] do go back to living at home and they're in that cycle and they're surrounded by Johnny, Mary, and whoever is using, so they have supports to get away from that. And it's like coming out of prison, same thing, that we are trying to develop new systems, programs that will support people getting out of that cycle that they want to get out of, so they've gone through their detox and their ready to go back in the environment they were in when they first left. That's a massive challenge, but it's something we're trying to develop."* As described in Chapter 4, the team works with clients to develop individualized, client-driven support plans to equip them to live within the environments where they began to misuse drugs. Because most clients will not be able to leave these environments, it is important that they become equipped to effectively negotiate challenges they will face and, hopefully, prevent relapse. The team's approaches to helping build clients' support services in the community are described in a subsequent section of this chapter, and the team's ambitions to enhance and grow their capacity to deliver this aspect of their service are described in the final chapter of this report. The important point here is that the team delivers a service that is congruent with key stakeholders' priorities, and they hope to build their capacity in these areas.

Relationships with General Practitioners

KEY STAKEHOLDERS' IMPRESSIONS OF THE PROGRAMME'S OUTREACH TO AND RELATIONSHIPS WITH GPS

The team has established a reputation for working very well with doctors in the region, providing them with effective supports believed to be important to reducing risk and to relapse prevention during a benzodiazepine detox. One Key Informant said: *"The thing I've been impressed with is the amount of GPs they got to, to inform them of the service, and the amount of GPs they've got on board has been really impressive. Some of those GPs are in it now three four years… which, so I've been very impressed with that."* As described in more detail in the subsequent section on other drugs' services relationships with the Novas CD, one Key Informant described his impression that the Novas CD functions as an important "safety valve" to GPs, slowing down the detox process through the use of the protocol stages and guidelines.

DOCTORS' EXPERIENCES AND IMPRESSIONS OF THE PROGRAMME

With one exception, every doctor who was reached for comment on this programme had very positive appraisals, appreciated the supports provided by the team, and respected the team for their competence, skills, and expertise in the area of drugs services. Doctors appreciated the presence of team members at meetings with service users. They

described the ways in which the support provided by the team afforded them a level of confidence that they could safely deliver a community-based detox. Doctors also appreciated the complementarity of the team's expertise to their own medical expertise. One doctor said, *"I felt empowered by the counsellor who was also advising. It was a good experience"*. Describing a difficult situation with a service user, one doctor said: *"[The Keyworker] seemed to know his stuff, and he was doing his best to try and uh, and he was well able to, you know, rules were being broken by the patient, and he [the keyworker] was well able to stand up and say, "this isn't good".*

The keyworker who worked with this client had similarly positive reflections on the experience of working with this doctor to address this client's challenging behaviours. This keyworker described how the service user was believed to be supplementing his prescribed dosage with benzos from another source, and had even forged a prescription. *"[The client] denied it and then his behaviour became not equal with the expected behaviour. He wasn't changing sufficient to the period of time he was on the detox, so it became apparent that something was amiss. So then he, without ever having really adhered to them in the first, place, he forged a prescription so we agreed with [the doctor] it was there was no point in continuing. So we stopped at that stage and I went with the client to [the doctor] and [the doctor] told him and I told him...So it was a difficult case, but nevertheless I felt that, while the beginning might not have been ideal, I felt that the success came at the end when both, two of the three parties worked together, and to me that was the success and that copper-fastened the need always to adhere to the protocols."*

Speaking in more general terms about the value of working with the Novas CD, one doctor said he would not attempt to detox a client without the support of the team. The team's dedication to attending GP appointments with clients is appreciated by this doctor, who said the presence of keyworkers with clients is absolutely necessary because their presence assures him that there is someone to check in with the patient and provide counselling. His impression is that keyworkers are vital to the detox process because *"you can't just leave people on their own when they are this severely addicted to benzos and trying to detox from them. They have poor coping skills and don't know how to manage stress. If the CD can develop methods of working with clients to help them build non-drug strategies to deal with stress, they will have addressed the core issue of addiction. The team helps create a situation where you know where you stand with a patient and helps you trust a patient. He values that very much – he doesn't have the time to spend with a patient or the skills to do the counselling."* He added further that although some of his GP colleagues do attempt detoxes without the support of a detox keyworker, he thinks this is unwise. He worries without the support of the detox team that GPs risk becoming a means to subsidize a patient's habit.

For doctors who are sceptical about the effectiveness of detox, the community detox team is a particularly important resource. One doctor said the counselling provided to service users by Novas CD was "exceptionally important" to a successful detox because *"the only chance' a service user has to succeed is with counselling and supports. Novas offers doctors a level of confidence in clients and removes or reduces worries that the client is coming in asking for detox when they run out of money and can't access on streets or to supplement what they are getting on streets."* This doctor said he finds it "really depressing" when he tries to help someone detox and then realizes they are just using the detox as a pretence to supplement their drug sources. Now, he won't do detox without the back up of drugs services.

One doctor expressed his appreciation for the time that Novas CD frees up for him in his practice, because the supports that detoxing patients need are extensive and time consuming: *"yeah, well, you know, we're all on a team and I don't expect to be able to detox people or counsel people off medication or [] whatever illicit drugs like that without the counselling, that sort of thing...[It's okay, but it's] time consuming, you know, not exactly... we're running a business here, and it's not exactly conducive to operating a successful business, putting all that time into one person".*

Only one doctor expressed any sort of frustration or disappointment in her experience of working with Novas CD. This doctor, who said she had worked with two or three clients, described one of the clients as "very aggressive and problematic". When the client missed appointments and Novas disengaged with the patient, the patient continued to show up at her office demanding prescriptions. This doctor said she felt unsupported by Novas and was left with the impression that Novas only works with easy clients, not clients who are not able to engage with the programme. This singular negative experience is clearly the exception to the rule because the preponderance of evidence from case notes, team interviews, key stakeholder interviews, and service user interviews indicates that the team works with individuals with the full range of support needs and challenging behaviours. However, this doctor's impressions do highlight the challenges of negotiating the three-way relationship between service user, keyworker, and client, and the team might consider the development of best practices guidelines for how to prevent, or minimize the potential for this situation to emerge.

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And finally, despite the team's best efforts to engage doctors and encourage them to deliver a community-based detox, some doctors simply will not be interested or convinced that it's a worthwhile endeavour. The team has worked with some GPs who have very little experience with detox and have low levels of confidence that a patient can be successfully detoxed. For example, one doctor said: *"I'm still a little bit, 'what's the point of it all', you know, in the end you know...So you know, I'm- I'm- I'm not as a GP not totally mad about the whole experience. I don't really want to get involved with patients who are drug addicted. Maybe that's a reflection of my weakness and my ability to treat it. Not sure. It's a reflection of the patient themselves [who] are very difficult, you know? Are they fixable, really? That is the question."*

Negotiating relationships with GPs is sometimes challenging for the team, who described both positive and negative experiences with GPs over the years. One keyworker said: *"... by and large all these experiences have been positive and- and I think the more doctors realized that we are present and- and that were there every week, and that we are, I think we're all delicate about our suggestions to them..."* However, keyworkers did describe doctors' "bedside manner" in variable terms. One keyworker contrasted experiences with GPs this way: *"One doctor said at the start of it, he said, I'm giving you a detox [for] a few weeks. That's it. Take it or leave it, I'm sick of you!" You know those this sort of stuff - whereas another doctor will encourage clients and say things like "come on man, you can do it, you can do this!"* A doctor's approach to his or her patient is an important aspect of client's support and overall experience of the community detox programme. Poor bedside manner can create challenges for the team and client, in that it discourages clients and makes the keyworkers' job supporting, encouraging, and motivating clients that much more difficult.

Poor bedside manner can negatively affect the team members, too. For example, one keyworker said, *"there's one GP that comes to mind; he puts the fear of God inside of myself. What's it like for a client? Because you just feel you feel, I've walked out of his surgery feeling like I was something he brought in on the heel of his shoe."* This is important because the client and keyworkers' experiences of the doctor, and the doctors' approach to community detox, influence both the quality of the client's experience and the quality of the keyworker's work environment.

CLIENTS' EXPERIENCES OF DOCTORS

Interviews with clients indicated their experiences with doctors were less positive than their experiences with the team. Common to these stories were clients' experiences of doctors' rigid adherence to tapering schedules without much apparent concern for clients' comfort. One client said of her doctor: *"she listened, but she wasn't flexible*

with the medication. She tried to cut me from four milligrams straight to two, and I was trying to explain to her that's not going to work with me... to be honest I wasn't ready to come off medication but she just cut me off medication and I got so sick from them I didn't go back to her... yeah, to be honest I should have done with another few weeks cause I'm still not sleeping enough and my weight then is up...Yeah I just quit my medication and I didn't go back to her." This example illustrates some of the challenges the team faces in delivering a safe community detox, and is consistent with other Key Informants' descriptions of some GPs as wanting to deliver detox to their patients too quickly, and with team members' earlier descriptions of GPs as inflexibly offering "a few weeks of detox, take it or leave it". Importantly, in the Progression Routes protocols, doctors are advised to take detox very slowly, but interviews with doctors revealed that their familiarity with the details of the protocols is quite variable and probably on average, quite superficial. Novas community detox team members work to slow the process, but they are not always able to influence the doctors' preference regarding the speed with which the detox is delivered.

One client described how the tenor of her relationship to her doctor changed after she entered and completed detox, to the point where she chose to change doctors. She said, *"Well, I'm with a different GP now, 'cause after the detox I just like, they were just really funny with me like, if I went if I was in pain, 'cause I suffer a lot with UTIs. They kind of wouldn›t give you any pain killers or you know, over your history, which I completely understand, but because I did the program I kind of felt let down that they didn›t trust me, and it was the same with my partner. They wouldn't give him any in case I was going to take them, and I- they were just kind of a bit standoffish, so I left. But during the detox she was tough. The doctor was tough now. But she was good. She did stand by what she believed in, like."*

Clients' Experiences of Novas CD

Clients' experiences of working with the Novas CD were universally positive. By far, the most common responses from clients were that they had complete trust in the team, felt supported by the team, and could confide anything in the team. Clients described their sessions with keyworkers as "having a chat" with a person of equal status and value. This experience was reported by every client contacted for this evaluation, and it attests to the success of the team's concerted efforts to honour the dignity and worth of their clients. One keyworker described her approach this way: *"I suppose, [] how you interact with them, you know, that you be open with them, that you give them your undivided attention, that you give them that space, that time, that you don't question them too much. All done through a nice gentle approach, conversation, you're not bombarding them with questions, you're not cross examining, you don't use any sort of authority, we're both on the same page."* See the section below, Team's Techniques for Working with Clients, for more information on this theme.

JOBS, EDUCATION, AND ACTIVITIES OF DAILY LIVING

Interviews with clients demonstrated that the team actively works to encourage clients to identify activities in the community in which to engage, such as paid employment and education. One client who had completed both detox and aftercare described her initial resistance to her keyworker's encouragement to get out of her house and do something - initially, her response was "nope, I can't", but then she *"applied for a part time job, it's a cleaning job in Tesco's but I got it and three years later I'm still there."* Another client who was in the aftercare phase at the time of the interview described how she had recently gone from part-time to full-time work, and that her keyworker was helping her deal with the challenges and stresses of going from working four hours a day to working eight and a half hours per day. Other clients described a range of activities offered by Novas and other community resources like the local university. Opportunities for yoga and meditation were frequently cited by clients as valued resources.

EMOTIONAL AND PSYCHOLOGICAL SUPPORT

All clients described feeling that they could count on, and call on, keyworkers at any time, day or night. *"Even when I was in the last week of my medication, I went [on holiday] and Julie rang me and just cause I had a major panic attack over there my heart [pounding] in my chest and I didn't take my meds right, and she's been great like. Oh god yeah because it's a friendly environment as well like they'll ring you Sunday to Sunday like Julie if I needed to talk to her she's there for me like".*

Importantly, the team succeeds in communicating to clients a genuine concern for their well-being and an authentic interest in their lives. For example, one client said: *"she just she cared like, do you know? It wasn't just, I don't think it was just her job, she actually cared what was going on like. Even after I had him [her baby] now, we stopped the programme, she still called out to see me after I had the baby like... she still took the time to ring and to call out and see the baby after I had him."*

Many clients do not have any other sources of positive social support, and so for them, the team may be their only authentic sense of connection to others, of a sense that someone believes in them, cares about them, and can be relied upon and trusted. A common refrain was that clients found it easier to speak to and seek social support from outside than from within their families. Further, clients described the ways that key workers worked with them to develop insight into their own roles in conflict with their family members: *"Like any time I had a problem with anyone, she was only a phone call away, do you know? That's and it was grand, because she was a complete stranger, but I felt like she cared more than my own family did, do you know? 'cause I don't- don't get on with everyone. I was always fighting. I know that I was a major factor in that. I can see that now."*

FAMILY SUPPORT

Clients described the varied ways in which the team involves family members and works to re-establish positive relationships, to develop new communication skills, repair damage done through drugs misuse, and develop family members' understanding of what the client is going through. One client described how her keyworker got to know her family members and listen to their sides of the stories, then helped the client develop more effective ways of communicating with her family this way: *"Even with my family, like, she's been great to help them understanding [me]; [my family have] never understood me before. She's [Novas CD key worker] heard my mother's side of the story, she's heard my nana's side of the story, and she's heard my side of the story, but when she talks [to us,] she doesn't allow that she's on our side, or their side, [] and it just calms me down then and makes me think: instead of [] [my] mother, like ...at least now, [] if [my family member is] not listening, I'll write ... down [what I want them to hear and] give it to them on paper, and then they understand it, like."*

Other Services' Experience of the Novas Community Detox

Key Informants from other drugs services in the region highlighted the important role the Novas CD plays in decreasing the risks associated with community detox. As mentioned earlier, one Key Informant used the metaphor of a "safety valve" for GPs. As described above in the GPs experiences of working with Novas CD, this Key Informant from another drugs service believes that *"the CD workers act as a safety valve for GPs, who are reassured in providing a high risk service, when they know there is someone in the community checking in with the patient and looking after them."* This Key Informant went on to say that his impression is that some GPs don't have a very good understanding of detox, that they want to do it too fast, and that speed can cause more harm than good. His impression is that, by following the protocols, the Novas CD worker can slow down the process for both GPs and for

clients, who can be eager to complete the detox. This is the importance of the preparation meetings and diary work as laid out in the protocols. This Key Informant has worked with some of the clients who have gone through the Novas CD, and it is his experience that clients think the programme is difficult, but that the keyworker is a "*huge bonus of support and encouragement*." This Key Informant also said that clients who go through the community detox process and then return to him for rehab are "*far better placed and prepared for it because [inpatient rehab] is abstinence based, and so people who have come completely off the benzos can manage it better. It really- really- really works well, and is the perfect lead-in to rehab....It's a really good, neat service and it's too bad it isn't available nationwide.*" He also said he would like to refer clients from other locations, for example, in Galway, but unfortunately the Novas programme doesn't cover Galway and there isn't a community detox in that region.

Team's Approach to Working with Clients

Interviews with team members revealed the amount of time and effort they put into building relationships and trust with clients, as well as the tools and skills they put to use to build these trusting relationships. These efforts begin immediately, in the engagement and preparation phases of the programme. The drug diaries are an important tool in relationship and confidence building during the preparations stage and are used to assess a person's readiness for change: "*I feel the client will verbalize where are there at when they meet with ourselves will be very quick to give you the diary and goes, that's how I was and then verbalize what went on during the week but in the preparation stage. It very much varies from person to person, and we have to have a certain amount of weeks of diaries and engagement, I suppose to separate the wood from the trees, to see who is genuinely interested, and to see, you know what I mean, who's willing to give it a good go or not...I think that we recognize that this as well that the preparation stage has to be as it is, because you know, you have to get to know someone, you have to build a rapport with them, you have to build a relationship with them, you have to see where they're coming, from you have to see what their commitment level is, given the fact that you're dealing with benzos.*"

SENSITIVITY TO CLIENT'S PAST EXPERIENCES

The team is keenly aware that their client population has had negative experiences with authority figures - sometimes lifetimes of negative experiences - and work to relate to clients in ways that attenuate status differentials between client and keyworker in order to build clients' trust. "*A lot of the clients we would deal with...would have an issue with authority, and rightly so, because they've had terrible experiences, so you use a nice, steady, gentle approach. You use all the skills that you have: you'd be genuine, active listening, you'd be open, to be honest, mindful of your body language, and that is that. The client [will] talk to you bit by bit and you take it at their pace. You don't expect them to go at your pace. It's their programme and you're always mindful that they are your employer because if they weren't there, we wouldn't have a programme and you wouldn't be employed, so you go at their level and their pace and if they're willing to open up to you, [] you don't you know push them too fast, too hard. That's how the trust is built up and then they kind of think, "well, Julie's alright or Maurice is alright.*"

WHEEL APPROACH TO SUPPORTS AND RELAPSE PREVENTION

The team has taken a 'wheel approach' to interagency and community support building with clients. Their aim is to slowly but effectively replace the client's primary relationship with benzodiazepines with other, more adaptive relationships, beginning with the team and expanding outward to family, community, and other client-chosen personal and social resources and capacities. As described by one key worker, "*The primary relationship is the client and the benzodiazepine, and that is a central relationship when they come to us. Then you have the client the benzodiazepines and community detox, so we're after being introduced. And here along comes the GP, so this is the ideal, as we envisaged it, that as the client continues with community detox, support structures and enhancements to their life become apparent... and we try and help people to work towards so when it's gone we aren't back at stage one...So [for example] that's what the meditation is: an attempt at giving them...a different experience of the world so that when the substance is gone it's [their world] not empty.*"

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A WARM, INVITING ENVIRONMENT

Several clients commented on the warm, inviting, "cosy" atmosphere of the community detox meeting room. The keyworkers remarked on the efforts they have put into creating a warm space, in contrast to the cold and spare spaces that are often encountered in social services. They also commented on how the clients use objects in the space to facilitate conversation and connection with keyworkers. Interestingly, one object in particular, a statue of the Buddha, has emerged as a valuable resource for connecting to and developing intimacy with clients. For example, one keyworker said, "*I had, there was a woman here the other day. She had a rough week, she had very little to say, but she honed in on the statue there of your man [referring to the Buddha statue there in the window] and sure, she was asking me, do you believe in God do you believe in heaven, do you believe in hell, do you believe in this, do you believe in that, and we had a fine chat around our spirituality and this and that and the other, what might happen when you leave this plane, and where you go. And I'd say about after about 40 minutes of that kind of chat we got around to how your week was.*"

LINK CLIENTS TO OTHER SERVICES

The team members work diligently to link clients to other community resources. Sometimes clients do not qualify for other services because of their drug misuse, and the team will work with them until they do qualify. One team member described the breadth of their efforts in this area like this: "*you know like you would you would sometimes come up, come across people in the community with housing issues, so you would then come in with your appropriate housing body; with family support issues you know, young kids who might need a little a little extra help and a little dig out from, and you would link them in with Family Support Service, you would, when it's female, when it's health you know, you know, some of our females would have street worked and things like that in the past, so you would link them in with women's health, you would link them in with the Regional [hospital], and support them throughout all of that.*"

TEAM WORKS WITH CLIENTS WHO LEAVE AND COME BACK

Analysis of referral logs and case files demonstrated that the team will repeatedly engage with an individual who leaves the programme and wants to return. They believe that prior engagement is an important foundation for future success. One key worker described the process this way: "*This one girl I'm working with now, that I would have originally assessed in maybe July 2012, she was nowhere near in a shape for detox, and you know she fell out of the programme, but has come back around again this year, and she appreciates and understands the benefits of the diary, the benefits of the programme, of the preparation process.*"

TEAM MEMBERS' EXPERIENCES OF THE TEAM

Interviews with team members indicate that the team is a highly cohesive and effective team

who are passionate about their work and enjoy working with one another. They have developed methods and strategies to deliver community detox that maximize efficiency and effectiveness. One team member put it this way: *"I suppose we are small team, and I have no qualms in saying we are very good team, you know what I mean, and we really are well connected together, and well bonded. We work so well together that we don't even have to give each other a nod and a wink. I think some of the things we do just happen to have just developed, and they've proven to work. I would never have sat down and have this magic, and had this writing it down, and this is what's going to happen after so many weeks or whatever."* However, if the team has developed procedures and strategies to deliver the community detox that they believe are proven to work, it would be useful for them, for future team members, and for other community detox teams, if they were able to document these strategies and develop an evidence base for what works and why it works.

Weaknesses or Gaps in the Programme

Key informants included doctors, clients, and key stakeholders with a range of different relationships to and experiences with the Novas CD programme. Across these different key informants, a great deal of confidence in and enthusiasm for this team was expressed. In fact, it was usually very difficult for Key Informants to name a weakness, gap, or dissatisfaction with the service. Only one doctor expressed some dissatisfaction with her experience of the programme, and this was described above in an earlier section. Thus, other than a single doctor who experienced problems with one client, Key Informants were hard-pressed to name a single weakness, and the evaluator did press each of them, sometimes quite firmly, to try to get a sense of areas in which the programme could improve. In the rare instance when a weakness or gap was finally named, it was either presented as a past problem that the team has already solved, or as a larger problem that is not actually within the team's control. The two issues that were raised had to do with regularity of steering group meetings and feedback from the team to other drugs services:

"…and one area that probably needed to be, um, looked at again was the steering group, and to be fair to Dan, we had that meeting. There was only a couple of us there a few people weren't able to make it, but I think the steering group is important… so you have relevant players referral bodies et cetera, coming, meeting, feeding into how the project is actually working and anything we can do to provide support for Novas…So if I were going to say something about the evaluation, that's definitely something that needs to be maintained 'cause [steering groups] work well. … To be fair, I was just flagging that they hadn't met in a while, and we met five six weeks back and there's a meeting due actually, shortly, so it's back on track."

Another Key Informant said that at first, there may have been a bit of staff turnover that made it difficult to get a hold of someone in the Novas CD office, and that it still might be two or three days before he gets a call back, but that is a drawback of team members only working part time for the CD. Also, when he refers clients to Novas CD, they don't always come back to him, and he wonders where they go. He would like for a team member to get in touch with him and let him know what happened to the client.

Recommendations

All Key Informants were asked if they had any recommendations for the programme or any ideas for the direction they would like the programme to take in the future. In this section, I summarize these recommendations and connect them to the programme's current practices and development plan (Chapter 7).

FEEDBACK TO REFERRAL SOURCES

As described above, one of the few gaps identified by Key Informants is information sharing. The team could review their policy and procedures for feeding information back to referral sources about client outcomes.

BROADER COMMUNITY FOCUS

Some Key Informants stated that they like the broader community focus that the team has taken, which goes beyond their initial proposal for the service. Initially, the Novas CD was proposed to fill a gap in drugs services for a group of homeless adults who did not qualify for any of the available drugs services in the region. Some Key Informants felt that the original target population was too narrow, that they were heartened to see the programme take a broader community focus, and that they hope that the programme can grow this focus through additional funding, such as from the HSE, philanthropic funding, or private funding.

STEERING GROUP

One Key Informant emphasized the importance of regular (quarterly) steering group meetings to the effective functioning and participation of a drugs programme within the larger network of drugs services providers in the region. It is important that the steering group consist of Novas staff, representatives from referral bodies like the HSE. The steering group is seen as an important resource for information sharing about trends in drug use, but also about particular service users and rehab planning: care planning, care referral pathways, case management, and intimidation concerns. Key informants suggested that the Novas CD should be encouraged to maintain a regular schedule of three to four annual steering group meetings.

EXPANSION OF SUITE OF SUPPORT SERVICES

Key informants spoke about their ambitions to see the programme grow and become embedded within a larger array of services, within the larger Novas Initiatives host organization, and become, as one informant put it, "a little kind of continuum of care within an organization". Key informants observed that the Novas CD team is ripe for developing such a diversified service: "Yeah, they're good at it, they can manage it, it's bloody challenging work, but they can do it."

EXPANSION OF DRUG SERVICES TO ALCOHOL, OTHER DRUGS, TREATMENT OF INDIVIDUALS WITH DUAL DIAGNOSIS AND DUAL ADDICTIONS

Key Informants raised the seemingly intractable challenges of treating dual diagnosis and dual addictions, and voiced aspirations for this team to be on the vanguard of regional solutions to this problem. One Key Informant said he would like to see the detox expanded if possible. He would like to see the Novas CD work with clients on heroin and methadone detox, because there really is nowhere for them to go. It is unclear, however, that there is a great demand in the region for methadone detox. There is a protocol for methadone detox, but interviews with the CD Coordinator indicated that the demand for methadone detox is lower than the demand for benzo detox. Further complicating the matter is a high rate of dual benzo and methadone addictions in the region, and it is the understanding of this evaluator that the preferred order of detox is benzos first, then methadone. This issue is taken up again in Chapter 7.

Key Informants talked about the Novas CD team as having both the ethos and the competencies that are necessary to take the lead in treating poly-drug misuse. One Key Informant raised the issue of alcohol dependence and the need to address dual benzo-alcohol dependence in community detox and relapse prevention, and said that he would like to see the team obtain the funding and supports

necessary to upskill in this area. However, he also said, *"That's bigger picture stuff, that's national strategy stuff: are they are going to include alcohol in the strategy or are they going to have alcohol here and drugs here? And they've had that separation for quite some time now they have it for some reasons. From a law perspective it's one that can be a little complicated (minimum pricing and all this kind of stuff - that's another area of work) but for me, alcohol should be included 'cause poly-drug use is a massive, massive factor… they [Novas CD] are, they're ideally placed and, and, there are, there are, believe it or not, enough examples of alcohol only users as well, for example an issue we have is that the HSE drug and alcohol service don't provide services to individuals over the age of 25 who don't have an alcohol only dependency because they used to fall under the MH services."*

Accessing services for clients with dual diagnosis is a big challenge for this team. As one keyworker stated, *"I suppose the big barrier within the Limerick area is mental health, you know, and it's something that we are experiencing for as long as I'm in this line of work, as you know, pushing the book from one to the other: is it mental health or is it addiction? You know we are quite willing to recognize dual diagnosis from our end of the scale, but then mental health won't recognize it and they're telling you to deal with their addiction and they have to be drug free, they can't be using you know before will see them period so that's the big thing."*

The team is involved in a pilot effort at Dromin House North Tipperary Mental Health Service in Nenagh to treat dual diagnosis. The team's successes in this area could go some way to reducing barriers to mental health services that Novas CD clients encounter. As one keyworker described her experience working with Dromin House in North Tipperary: *"and it is proven to work very well, it is proven to work particularly in North Tipperary where another agency would be making the referral it would be drug and health…the addiction counsellor there …would be making the referral [to us] and for the first initial stage of the preparation, of me doing the assessment, and I suppose doing a bit of preparation work, getting the diaries up and going, he would work with me and even you know following along from that he would dip in and out all the time and that works really really well….I suppose it's kind of showing the way it is a big step forward and how we can work with dual diagnosis and it's nearly been an example for how we could work with the day hospitals here in Limerick, you know. It's something that we can build and work on with other agencies, you know, making referrals we've had referrals from CSMT some of the lads down there, and they are fantastic you know.*

A NEED FOR WOMEN-SPECIFIC SERVICES

Some Key Informants raised concerns about the gendered aspects of drugs misuse, with a focus on both the high rate of misuse amongst women in the Midwest Region and on women's particular needs and problems that arise from substance misuse. One Key Informant said: *"We have very high numbers of young women between late teens to early mid-thirties that are using. And all the issues that come with using. So, uh pregnancy, street working, domestic violence, etc., early school leaving…Our numbers are way higher than the national average. Way higher… bar Dublin…it's way above the national average. You're talking 20-odd percent."* Incorporation of women-specific services is on one Key Informant's agenda for drugs services projects within the region, and he would like to see the Novas CD add women-specific services to their programme.

SUSTAINABILITY

One issue that Key Informants raised is sustainability. At the moment, Community Detox fits under the *MWDAF* treatment and rehabilitation pool, so it draws from a pool of money along with other projects in the region. Because the programme has demonstrated itself to be a vital component of the continuum of care in the Midwest Region, it is important that it secure dependable funding for the long-term. One Key Informant said, *"it's a project that needs to stay given the nature of what it does."*

KEY FINDINGS, SUSTAINMENT AND DEVELOPMENT RECOMMENDATIONS

06

Key Findings, Sustainment and Development Recommendations

The first section of this chapter summarizes the key evaluation findings. The second section presents a set of key recommendations for sustainment and development that result from these key findings. These recommendations were generated in consultation with the CD Coordinator and Team Members and are intended to sustain and grow this this important community resource so that it may achieve its aim to satisfy Key Stakeholder interests and priorities and continue to safely and effectively deliver its service to residents of the Midwest Region.

Key Findings

KEY FINDING 1 – FIDELITY

The Novas Community Detox team provides community-based supports to clients and general practitioners with a high degree of fidelity to the Progression Routes Protocols. There are two important corollaries of this finding: 1) the team provides a highly effective and important service to the Midwest Region; and 2) the Progression Routes Protocols are a safe, effective, and cost-efficient means to deliver a community-based detoxification service.

KEY FINDING 2 – INNOVATION

The Novas Community Detox programme goes beyond the original Progression Routes protocols in ways that add value and increase effectiveness. The two most important adjuvant components are the expanded Broker-CD Coordinator Role and the dedicated key worker team members. Evidence from this evaluation suggests that outcomes for clients and general practitioners are enhanced when a team of trained drugs specialists deliver the protocols.

KEY FINDING 3 – IMPORTANCE

The Novas Community Detox Team provides a service that fills a gap in the Continuum of Care, such that clients are served who would not otherwise be able to access detoxification because they would not qualify for residential services, because waiting lists are too long, and because their use is too high for general practitioners to agree to provide a detox without supports.

KEY FINDING 4 – CLIENT SATISFACTION AND SUCCESS

Clients are highly satisfied with the services they receive from the Novas Community Detox team. The outcomes that have been obtained for clients, in terms of numbers of clients engaged, retained, returned, and completed, further support the conclusion that the team is providing a high-quality and much-needed service in the Midwest Region.

KEY FINDING 5 – GENERAL PRACTITIONERS' ENGAGEMENT

The Team provides valued supports to GPs who would otherwise not be comfortable delivering a community detox to individuals with such high rates of benzodiazepine use. Some GPs continue to have reservations about the potential for some individuals to successfully detox from benzodiazepines, but they often willing to take on the responsibility with the supports of the Novas CD Team. The GPs trust, respect, and rely upon the Novas CD Team to provide essential supports to reduce risk and support clients through detox.

KEY FINDING 6 – VALUE TO KEY STAKEHOLDERS

Key Stakeholders have a positive evaluation of the Novas Community Detox Team. The team was referred to as the "gold standard" for delivering the Progression Routes Protocols. The service is universally seen as a cost-effective means for delivering a service and filling a gap within the drugs services continuum of care in the Midwest region. The team members are universally appraised to be highly competent, passionate, and skilled specialists. Also universally, Key Stakeholders would like to see this team grow, both in size and type of services it offers to its clients.

KEY FINDING 7 – TEAM EFFECTIVENESS

Team members are highly knowledgeable, experienced, passionate, and committed to their work. They deliver the protocols with both professionalism and compassion. The team is highly cohesive, respect one another, and effective in their working relationships. The intangible but vitally important working relationships that have developed amongst the team members are one of the key ingredients that have contributed to their successes, which include widespread uptake of the service by general practitioners, respect and support of Key Stakeholders, and most importantly, their clients' high degree of satisfaction with their experiences of the service.

Recommendations

Given the success Novas Initiatives' CD team has had with their approach to delivering the Progression Routes Protocols to individuals detoxing from benzodiazepines, several recommendations for programme development and expansion are warranted. These recommendations fall into four categories: 1) broaden the target population; 2) increase resources; 3) Enhance regional presence; 4) Enhance national presence.

1. Broaden Target Population

It is recommended that Novas Initiatives broaden their target population to include individuals whom they could support through detox from other substances. Given the current rates of alcohol and codeine misuse and dependence in the Midwest Region, it is recommended that the team collaborate with experts to develop adaptations of the Progression Routes Protocols for alcohol and codeine, pilot and evaluate the delivery and effectiveness of these new protocols.

2. Increase Resources

Funding. In order to grow this important service, the team will require additional resources, especially funding. A dependable, ring-fenced funding stream is a necessary prerequisite to the team's achievement of their long-range development goals. The team should also apply for funding from additional funding streams, for example, funding streams that are tied to particular specialisms or target groups.

Space: Right now the team is at capacity in the space that they have, and although they use the space in creative ways, they cannot expand until they have more space. As the CD Coordinator pointed out, because it is community detox, the team members should spend much of their time in the community. But they need desk space, they need meeting space, and, if they do increase the range of services offered to clients, then they need space in which to deliver these services.

Staffing. In order to reach more clients with a greater diversity of support needs, an increase in staffing numbers is required. Currently, staff members are employed part-time on the Community Detox Programme. These staff members could easily fill 40 hours per week devoted solely to delivering community detox supports. It is recommended that staffing hours be increased commensurate with the level of development desired by Staff and Management. This could take the form of current staff moving from part-time to full-time, and/or the hiring of new team members.

Skills. Two areas of staff upskilling are identified as important to maximizing the effective support of community detoxification. The first is Trauma Informed Care. Given the substantial percentage of Novas CD clients with histories of trauma, it is important that all staff are trained in the delivery of Trauma Informed Care via the model of Psychologically Informed Environments (PIE). The second is Cognitive Behavioural Therapy (CBT). CBT is an evidence-based practice with a large body of research demonstrating its effectiveness for anxiety management. Benzodiazepine misuse is strongly associated with anxiety symptoms, and because virtually every Novas CD client to-date reports problems with anxiety that interfere with their daily functioning, it is important that each team member be trained to deliver CBT.

3. Enhance Regional Presence

Other Agencies. To maximize their capacity to support their clients through detox, and to capitalize on resources already available in the Midwest region, the team should continue to strengthen their interagency work in the sector with services such as ALDP and CSMT. It was suggested by some Key Stakeholders that the Steering Committee is underutilized. It is recommended that the team think about the composition of their Steering Committee and the ways in which they use the Steering Committee to ensure effective delivery of services and strong interagency connections at local, regional, and national levels.

GPs. It is also recommended that the team continue GP trainings in order to increase their involvement with Novas, their comfort and confidence in delivering community detox, particularly in line with the recommended guidelines as explained in the Progression Routes

Protocols. This training should be expanded to include other agencies like probation and social work, in order to increase understanding of substance dependence, knowledge of best practices for community detox, and empathy for individuals facing the challenges of substance misuse and detoxification.

Other institutions. It is also recommended to strengthen and enhance existing links between Novas and University of Limerick and Limerick Institute of Technology. The development of practitioner-researcher interconnections, perhaps through a series of annual seminars or meetings, in which information can be shared about theory and practice. These may be part of professional development, training, and outreach. Linking with UL and LIT in official capacities can increase the profile of all three institutions.

Geographical Reach. It is recommended that staffing grow to allow for the development of a greater presence throughout the region, where coverage is necessarily thin because of the small, part-time staff. The presence of the team at Dromin Day Hospital in Nenagh is well-established, but opportunities to grow beyond the connection to Dromin should be explored. The geography, size of the region, and spread of the population into rural areas make it difficult to grow services in Clare, Limerick County, and North Tipperary. It is recommended that the team and its management explore opportunities to create satellites in sites such as West Limerick, Ennis, Thurles, and Newcastle West, which could be staffed with individuals who can network and build relationships with service providers and GPs

4. Enhance National Presence

At present, Novas statistics are not included in the Health Research Board or NDTRS reports because only inpatient statistics are included. This exclusion of outpatient and community-based services systematically underrepresents both the extent of need for services and the volume of services provided in response to this need, especially in the Midwest Region. Because the level of services provided by Novas CD in the Midwest Region is substantial, this means that rates of use and service provision documented in these reports underrepresent both the level of benzodiazepine use and the intensity of drugs services in this Region. Novas Community Detox statistics should be included in these national reports in order enhance their national visibility, but also to improve representation and accuracy of national estimates of benzodiazepine use.

APENDIX

Quantitative Data

INITIAL REFERRAL FORM

- Date of referral
- Age
- Sex
- Location
- Employment status
- Type of accommodation
- Number of dependents
- Child care arrangements
- Legal status – citizen/immigrant
- Nationality
- Drug preference & current drug use
- Injection history
- Age of first drug treatment
- Previous types of drug treatments ("drug contacts")
- Methadone – current, amount, duration
- Prescribing doctor
- Other medications
- Medical card
- Legal situation – Legal issues
- Referral source
- Other support services

TREATMENT OUTCOMES PROFILE (TOP)

- Substance Use: Measure, average daily, weeks 1 to 4; I need this measure explained to me
- Alcohol
- Heroin
- Methadone
- Crack/cocaine
- Amphetamines
- Cannabis
- Ecstasy
- Benzos prescribed and unprescribed
- Other sedatives
- LSD
- Other

INJECTING RISK BEHAVIOUR

- Number of days injected
- Times injected per day
- Used by someone else
- Spoon water filter used by someone else

Health and Social Functioning
- Psychological health
- Physical health
- Housing problem, risk of eviction
- Quality of life

Record of Disengagement
- Date of disengagement
- Stage at which disengaged
- Y/No continued contact
- Reason for not beginning detox (as appropriate) OR how disengaged during detox

Qualitative Data

CLIENT INTERVIEW GUIDE

1. Tell me a little bit about yourself.
2. Describe the admissions process – referral, assessment, meeting with the coordinator, meeting with the MD, meeting with the key worker.
3. Describe the detox process and any particular aspects of it that you think are important.
4. Strengths and weaknesses of the programme for you.
5. Did you complete the programme? At what point did you discontinue?
6. Describe experiences of the preparation period.
7. Describe experiences of the detox period.
8. Describe experiences of after care.
9. Describe experiences of leaving/finishing/ disengaging from the programme.

* *Prompts for the above: How did you experience the pace of the programme – the preparation period, the prescribing period, and any other part of the programme?*

10. Describe any experiences of relapse.
11. What kinds of services are there for you now? What do you think you need?
12. Would you reengage with the programme?
13. How satisfied are you with your experience of the programme?
14. Would you recommend it for other people?

GP INTERVIEW GUIDE

1. Describe your experiences of and general appraisal of the community detox programme.
2. How many clients have been referred to you, how many have you accepted?
3. What were your experiences of working with the coordinator/broker and the key workers?
4. How familiar are you with the community detox protocol, what are your thoughts about it?
5. What do you think works, doesn't work, could be improved about the community detox programme and protocol?
6. What are your thoughts on clinical governance?
7. Thoughts on dual addictions and dual diagnosis
8. Treatment concerns – reservations about participating
9. If you haven't accepted any patients, why? If you've declined to take on some referrals, why? What were your concerns?
10. What are your thoughts on clinical governance?

KEY STAKEHOLDER INTERVIEW GUIDE

1. Is the programme providing treatment options that weren't there before?
2. Do individuals who need it avail of it?
3. Do the doctors benefit from the supports provided by the key workers?
4. Does it help them deliver this high risk medical service?
5. What is the value of programme?
6. What are its strengths and weaknesses?
7. What is its relevance to or role in providing drugs services in the Limerick context?
8. How does it function, in terms of governance and oversight? In terms of operations and management?
9. What are your expectations for the programme moving forward?