Current Model of Drug Care

Treatment Detox Rehab

Components of a Full Drug Care Service

(1) (2) (3) (4) (5) (6) (7) (8) (9)

Community Preparation Treatment Detox Rehab Community Community
Prison work Halfway awareness
teams detox house

(1) Requires work in schools, and via media to raise understanding, and reinforce the message that drug dealing is a crime, but drug usage is an addiction, and needs treating as such.

(2) Currently, patients can request residential detox and rehab, and are added to a waiting list for detox. Best practice would advise preparation and assessment of motivation, so that patients don't enter expensive treatment till motivation good, as a failed detox or rehab is not just a waste of money, but reduces motivation and encourages long-term drug use.

(3) The current methadone programme has moved clients from injection and criminality to smoking and no crime. Buprenorphine, preferably with naloxone, is more expensive, but better tolerated, and blocks usage of heroin on top, and stops misuse. It is also much easier and quicker to reduce and stop when stable. Buprenorphine stays in the blood for 48 hours, so alternate day supervision is possible, so cheaper. The combination with naloxone has no black market value.

(4) It is best practice for certain groups to have residential detox, ie patients who have failed community detox, patients with other physical or mental illness, and patients with unsatisfactory home situations, but the majority of patients can have a successful community detox, with the right support, which is much cheaper, and doesn't remove patients from their home situation, and so lessens stigma. Lofexidine is more expensive than clonidine for detoxification, but more effective, with fewer side effects. It is therefore safer in community settings. Elsewhere in the world, patients would be stabilized on methadone or buprenorphine, then undergo a detox, so it is unlikely that patients would have withdrawal fits, so community detox is safer. This would save the cost of valproate to protect fits, though this can still be used safely in the community.

(5) Although I am not an expert, I believe the evidence for CBT approaches in rehab is better than for a therapeutic community model, but both can be combined. The above comments about preparation apply equally to rehab. One of the important missing links for detox and rehab is the use of Naltrexone before discharge, and continuing for up to 12 months to minimize relapse. It is a pure opiate blocker, so if taken daily, patients won't use heroin as they gain no benefit. Naltrexone can be administered 3 times weekly without losing effectivity, so can be supervised more easily. A naltrexone implant is manufactured, but is not licenced in the UK, so I have no experience of it. Perhaps this could be researched. Improving the specialist training for counselling in detox and rehab, and introducing protocols about best practice will improve outcomes.

(6) The only way I can see to offer excellent drugs care across all the Maldives is by developing community teams based in each province, or each atoll. These can effectively address all the 9 components apart from residential detox, rehab, prison work, and halfway house. Care will be more accessible, within their community, and cheaper, as well as more effective. I am attaching a separate paper addressing possible configuration and function.

(7) As stated above, community detox is more effective for most patients, and they have the advantage of family support.

(8) Unofficial figures suggest that over 80% of prison inmates have a drug problem. If drug misuse was regarded as an addiction, ie an illness, then there is facility for preparation (2), treatment (3), and detox (4) in prison with the right prison drug team. This could effectively deal with drug use in prison, and could prepare prisoners for a drug-free life after release. Use of Naltrexone in prison could also deal with usage in prison and potentially reduce jail terms, saving considerable expense. The work Journey and SWAD (NGOs) are doing with released prisoners seems good, and could be built on.

(9) I gather a halfway house has been planned but is not yet in being. With good assessment for suitability, this should be a useful facility for certain drug misusers, as long as the right psychological therapies were available.

I don't see that any of the above can be left out of a good comprehensive drug service. There is considerable extra initial financial outlay in the above, but potentially much larger savings to be made in the longer term. The savings should be across the prison and judiciary system, as well as in healthcare.

Proposed Configuration of Community Teams

I don't profess to have expert knowledge of the demography and geography of the Maldives, but I have first hand experience of the clinical effectiveness and cost-effectiveness of community teams. There are currently small atoll-based social work teams which are working effectively. There is need for community drug teams, and also for community mental health teams, and there are good arguments for co-locating them, or even combining them into 1 larger team, so increasing cost-effectiveness by sharing admin support and buildings. Also, supervision is easier in larger teams, and 1 team usually functions better than several.

My suggested minimum membership of such a drug team would be:-

- Community worker/s: to address awareness-raising, health promotion, and prevention work.
- Drug worker/s: to assess motivation, and prepare patients for treatment, detox or rehab, and to do follow-up work after.
- A nurse or doctor to initiate treatment and monitor progress, to conduct community detoxes, and refer for residential detox or rehab as needed.
- A dual diagnosis worker to address concurrent mental health and drug issues.
- A youth worker to tackle drug issues in the under 18's, ?with links to the Juvenile Justice system
- A counsellor to offer appropriate therapies.
- A manager to oversee the team, offer supervision, and chair regular team meetings, and communicate with DDPRS

Mental health is understandably a lower priority in the Maldives, but is nevertheless important, and likely to become increasingly important. More than 1 in 3 of all health consultations in the community in UK are due to mental health problems. With only 4 psychiatrists in the Maldives, and very few clinical psychologists, there is a much larger issue of training to offer good mental health care to the population. Community teams seem the only way to reach the population effectively.

My suggested minimum membership of such a mental health team would be:-

- A psychiatrist or doctor with appropriate mental health specialist training, to assess patients and manage medication.

- Community mental health nurses to work with patients, work alongside the doctor where needed, assertively reach out to challenging patients, manage long-term conditions, follow up patients discharged from inpatient care,and liaise with other agencies.
- A post traumatic stress disorder counsellor to work with victims of child abuse, and work with patients who attempt suicide.
- A child and adolescent nurse/counsellor to work with under 18's, and to address early intervention for psychosis.
- A specialist nurse for the elderly to address elderly issues, particularly dementia, and to offer family support.
- Counsellor or clinical psychologist to work with patients as appropriate
- Social worker to address social needs, perhaps recruited from the 16 social workers trained each year.
- Manager and admin support

Maybe several of these posts could be amalgamated depending on need and funding. If the drug and mental health team were amalgamated, savings could be made, and professionals could work across both. The social work team could also be amalgamated or share premises, or share some staff, ie using a drug worker or child/ adolescent worker. Would there be conflicts of interest if teams were amalgamated? Male has very different needs from other atolls, and all atolls will have different populations and needs from each other, so teams can be adapted. There is also possibility to share certain professionals, ie psychiatrists, across several atolls, or have a mobile team visiting all atolls, or have telephone advice from the more experienced to support the less experienced.

I also feel strongly that global healthcare can be stabilized and strengthened by a robust system of community-based general medical care, including doctors and nurses, who should be able to handle the vast

majority of health problems and only refer a small percentage on to specialists. This requires a change in public expectation, and so couldn't happen quickly.

Since the drugs issue is one of the government's 5 high priorities, it seems vital to seek short term cash injection to make a more comprehensive service work. I would be delighted to be involved further in any way if helpful