

COUNTRY REPORT

COMMUNITY MOBILE TREATMENT FOR SUBSTANCE ABUSE

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Abstract

Objective: To discuss and share regarding a highly accessible approach in substance abuse management. **Methods:** We report one of the most innovative ways of providing street-based services is by using Mobile Outreach Vehicles (MOVs). **Results:** MOVs are usually large vans, trailers or campers, converted to provide services in targeted communities. Well-equipped MOVs are effective because MOV-based programmes meet at-risk individuals in their neighbourhoods. MOVs can move to different neighbourhoods as drug traffic migrates from place to place. An MOV can enhance the credibility of a project by becoming a recognizable presence in high risk neighborhoods. A greater amount of privacy, safety, and resources can be provided using MOVs. Among the most important factors that determine the effectiveness of drug abuse treatment programmes is the accessibility of services and the duration that patients are maintained in contact with those services. **Conclusion:** Treatment access is determined largely at the local level, where most services are offered. De-addiction services should be designed and provided in a way that increases the trust of substance users and their families. There is a need to look into the possible low-threshold, low-barrier approaches to the management of substance using populations. *ASEAN Journal of Psychiatry, Vol.12(2): XX XX.*

Keywords: Mobile treatment, Community, Substance abuse

Introduction

Over the years, substance use management has witnessed a never ending quest for understanding the bio-psycho-socio-cultural aspects of the condition. This lookout for the ever elusive gold standard has given different approaches to the understanding, assessment and management of the issues related to substance use. One of the major hurdles in the area has been the feasibility and applicability of these discoveries and inventions to daily practice. Management of substance use related conditions can be carried out in a multitude of settings like emergency departments and outpatient departments of a general hospital, outpatient and inpatient setup of a dedicated substance use treatment centre, community based intervention centres, and self-help groups among others. However, each of these

approaches has its own limitations and drawbacks coupled with the benefits they provide. The issues of behaviourism related to the drug use problem make the transition from confined micro-society experiments to the unconfined macro-societies that characterize the natural ecology of drug abuse treatment one of the biggest challenges.

Factors affecting the programme effectiveness

The substance use treatment services literature has examined a wide range of personal and environmental attributes that influence effectiveness of the available services. These include demographics, health status and functional limitations, severity of condition, socioeconomic status and employment, patient view of the

problem, acculturation, ethnicity, community support, provider sensitivity, structural & operating aspects of providers, and a variety of economic and financial barriers.

Among the most important factors that determine the effectiveness of drug abuse treatment programmes is the accessibility of services and the duration that patients are maintained in contact with those services. There has to be four essential elements for 'good' medical care, one of which is accessibility. Accessibility was defined in terms of personal accessibility, comprehensive services, and quantitative adequacy. Personal accessibility means that there must be defined points of entry into the health care system. A comprehensive range of services is needed because complex problems may require input from a variety of specialties. Quantitative adequacy refers to the supply of a comprehensive range of personal health services sufficient to meet the need.

A widely used definition of access was developed by Aday et al (1984): "...those dimensions which describe the potential and actual entry of a given population group to the health care delivery system. The probability of an individual's entry into the health care system is influenced by the structure of the delivery system itself ... and the nature of the wants, resources and needs that potential consumers may bring to the care-seeking process" [1]. Donabedian (1973) developed a similar concept of access, but focusing on the health system —"access comprises those characteristics of the resource that facilitate or obstruct use by potential clients" [2].

The services system can act as a barrier to access. Treatment access is determined largely at the local level, where most services are offered. Local market area studies of substance abuse treatment have indicated that specialty services are concentrated in more urbanized areas, providing urban populations with better

access [3,4]. Capacity or the availability of supply is crucial to understand access (and meet treatment need); both are influenced by the composition of treatment ownership, organization, and services and specialty [5].

A review by Ward et al (1998) indicates that some of the programme factors that are most likely to improve retention include accessibility, affordability and convenient hours of operation [6]. Weisner & Schmidt (2001) remarked that in spite of increase in the availability of treatment for opioid dependence in Australia, concerns about the accessibility of addiction treatment remain [7].

Joanne Neale, while studying the drug users' views of drug service providers observed that most respondents, both substance using men and women, felt that controlled drugs should be dispensed through an easily accessible site rather than a centralized clinic. This meant saving time and money spent on travelling to the centre and the speed of dispensing service among other reasons. Moreover, some of the respondents came up with the alternative dispensing arrangements in form of a mobile bus which they personally considered preferable either to the pharmacy or clinic.

Various national surveys in the country have reported that treatment-seeking in substance users is rather low. Drug Abuse Monitoring Survey (DAMS) has reported that only 27 % of the current treatment seekers have sought treatment for their substance use problem in the past. National Household Survey (NHS) reported this figure to vary from 2 to 19 % [8,9]. This highlights the need for developing a service delivery system that is more easily accessible to the potential beneficiaries. This could be carried out by either bringing the patients to the establishments, that is, treatment centres, or taking the services closer to the patients. While the earlier approach would mean efforts to offer the effective treatment modalities, it would also need to overcome the initial barrier of bringing the patients to

the centres. By bringing services close to the patients, one could expect a circumvention of the initial hurdle, at least in part if not fully.

Low-Barrier/ Threshold Models of treatment delivery:

De-addiction services should be designed and provided in a way that increases the trust of substance users and their families. Various low-barrier services models have been studied for substance using population. The underlying thrust of these models is to bring social services to the community-to remove barriers to service accessibility and availability. Storefront multipurpose service centres, low-barrier drop-in service centres where substance users could receive services with minimal or no requirements could try to reach the difficult-to-access substance user who shuns the formal treatment and service systems. Street outreach can provide drug and infectious disease-related information and services to individuals who do not otherwise have access to them. Research suggests that substance users can be particularly suspicious of medical professionals and institutionalized services. There is a need for mobile vans and a cadre of 'foot soldiers' to go into the shooting galleries and shelters where the potential beneficiaries of the substance use treatment reside. As street outreach often uses indigenous workers from the target community, outreach-based projects may have more success at establishing trust and rapport with community members because staff is perceived as peers.

One of the most innovative ways of providing street-based services is by using Mobile Outreach Vehicles (MOVs). MOVs are usually large vans, trailers or campers, converted to provide services in targeted communities. Well-equipped MOVs are effective because MOV-based programmes meet at-risk individuals in their neighbourhoods. In this way, they accommodate the people they serve. MOVs can move to different neighborhoods as drug

traffic migrates from place to place. An MOV can enhance the credibility of a project by becoming a recognizable presence in high risk neighbourhoods. A greater amount of privacy, safety, and resources can be provided using MOVs.

Mobile services with a multidisciplinary team of medical, case management, and prevention staff would provide more direct access to treatment services. Mobile services concentrated in communities with high prevalence areas and satellites of larger health care facilities would be of help in overcoming some of the barriers in the utilisation of the services for substance use treatment. Being a low-threshold service delivery model, such an approach would be open to a wider range of patients and would have lesser restrictions.

Mobile services aimed at ensuring substance abuse treatment services to patients where they reside help to develop alliances between mobile health, communities and existing biopsychosocial services. They help to foster community partnerships and collaborations that promote the expansion of medication assisted treatment by assisting similar programmes to expand this continuum of care.

Mobile clinic

Mobile unit:

It is a mechanically, electrically, propelled vehicle operating on land or water. Other terms/names used are such as *mobile treatment, mobile community treatment, community initiatives, methadone by van, mobile methadone treatment, methadone on road, and Mobile Outreach Vehicles (MOVs)*. Wiebe et al preferred the use of the term '*community mobile treatment*' since it incorporates the efforts of the 'mobile treatment team' as well as the 'mobilized community' in this community based approach.

Abbas (1989) defined the community mobile treatment as "...an intensive alcohol and drug treatment programme implemented

by a team of facilitators in conjunction with and with the approval of the community at large". This definition precisely sums up the two most important components of this outreach approach- the treatment team and the community of which the substance users are an integral part. This definition also highlights the dynamic rather than the static nature of the concept as an ongoing and ever modifying project receiving and providing inputs from the interaction of the treating team, the patients and the community.

Such outreach programmes have been successfully utilized to provide treatment for HIV & other infectious diseases, counseling, testing & risk reduction activities, conduct early disease intervention for difficult to reach HIV-infected populations, exchange injection equipment, dispense methadone, provide health services, and perform crisis intervention. Special populations that have been successfully targeted by outreach programmes include active drug users, commercial sex workers, methadone maintenance patients, runaway youth, homeless people and mentally ill persons.

Rationale

The mobile clinic for substance use treatment enjoys the advantage of approaching the people who are still using opioids and incorporating them into treatment. Hospital-based facilities of the management of substance use disorders, although comprehensive, rely heavily on the patient's ability to initiate and maintain treatment within a structured system. This invariably means strictly scheduled visits. The nature of the substance use or the circumstantial factors could mean an avoidance or lapses with these schedules. Family or work responsibility could hold back the treatment seekers from leaving their community for an extended period of time or even a shorter but regular and frequent basis. Fear of the unknown larger centre or entering a treatment process little known has also been cited as reasons for not availing the available services.

The mobile treatment team helps patients by bringing the services closer to them and keeping the schedule for them by offering treatment within their neighbourhood on a designated schedule. This approach thus creates a system in which people are comfortable seeking treatment and hence ensures that the treatment is accessible when needed. Additionally, by involving as many community members as possible in the process 'the community mobile treatment attempts to create an observable ethic which encompasses the community's stance on alcohol and drug use' [10].

Inception

In 1979, the presence of around one thousand heroin users in the centre of Amsterdam created an urgent need for medical and social assistance. Since these substance users refused to attend local healthcare clinics, a rebuilt city bus was hastily enlisted to dispense methadone at 6 locations daily. As a 'harm reduction' effort, the programme also distributed clean injection needles and condoms. The 'Amsterdam model' of mobile methadone dispensing came into being in the 1980s. In order to overcome the limitation of the existing service delivery system and to bring the benefits of the available treatment modalities closer to the substance users, Paul Hanki of British Columbia, Canada started *mobile treatment* in 1984.

The change in the drug policy of some European countries also paved the way for a more simplistic and more user-friendly approach of treatment delivery. The concept of Amsterdam Model was soon taken by other cities in Europe through the Frankfurt resolution during the next decade.

Community mobile treatment: An event or a process?

Community mobile treatment is an intervention strategy that relies on the integrated efforts of the service providers

and the service utilisers with the aim of benefitting the community at large. This calls for a coordinated and ongoing collaboration between the two most essential components of the approach, i.e. the treating team and the community, including the substance using population. While the service delivery through the programme can be considered an *event*, the approach is an ongoing *process* aimed at improving the service delivery. Before the programme can actually be put to practice, a lot of work goes in involving and mobilizing the community. This would include installing hope in the community about a possible solution to the problem of substance use and that change can be brought about by concerted effort. This initial *process* lasting around 1-2 years helps in ensuring the committed involvement of the community in the programme. Once the initial *process* sets in, the next step of the service delivery i.e. *event* takes place. This again is followed by the *process* of ongoing community involvement. Thus community mobile treatment would best be described as a combination of a *process* and an *event*, both aimed at the ultimate goal of providing treatment services to the substance users in their community.

Target population

The target population includes homeless individuals, people who will not often seek treatment within established structures, and/or patients who have trouble maintaining the schedule and motivation necessary to continually attend inpatient or outpatient sessions. Mobile clinics aimed at specific sections of populations like sex workers and immigrant population have also been in practice. Another patient population that benefits from this approach is patients who are ‘suddenly’ ready to be treated. The mobile unit offers the opportunity to initiate treatment immediately, which might be simpler and convenient than entering an inpatient or outpatient setting of treatment centres. The patient base for the service would need to be defined so that the

inclusion criterion for the programme is clear. Programmes like Amsterdam model require the treatment seeker to be a registered resident of the city and not enquire about the locality they reside in. However, such an approach might not be practical for the zones with heavy patient load and depending on the availability of the resources one would have to define the area to which the service would be delivered. This would mean use of some kind of proof of residence in the area marked by the team. The outreach members of the team in consultation with local community representatives may arrive at a conclusion regarding the area of stay of the specific individuals.

Attributes of a mobile clinic

Community mobile treatment can be modified as per the needs of the local community. Various factors need to be taken into consideration while planning such an intervention. The description below could be of help in planning such a programme. These suggestions are primarily based on the available information from various ongoing programmes of this nature and might need modification as per the local needs.

Services offered

The community mobile treatment is aimed at drug users, their sexual partners, and significant others, to provide education, prevention, and early intervention services. The services provided may range from IEC activities, dispensing of medications, physical examination and treatment of physical conditions, HIV screening, condom dispensing, needle-syringe exchange, anti-retroviral therapy dispensing in isolation or in varied combinations. Literature about and referral to other health and social welfare concerns is also available.

Components

The Tasks

Management: Good management of the programme includes a clear description of each position and tasks, regular supervision, regular team meetings, and case management. Clear procedures within a programme are important for the staff and have an impact on the expected treatment outcome for the patients.

Medical care: Medical care is provided by doctors, psychiatrists and nurses. Prescribing is the responsibility of the doctor signing the prescription. It is the responsibility of all medical personnel to provide care for general health needs and drug-related problems. It is the clinician's responsibility to make sure that the patient receives the correct dose and that the drug is used appropriately and not diverted onto the illegal market. Particular care must be taken with induction. Doctors need to undertake clinical reviews of patients regularly, at least every two or three months, particularly of patients whose drug use remains unstable. While the issues relating to the dispensing of the drugs for opiate abuse/ dependence would be handled by a specialist clinician, other general health issues can be well taken care of by a medical graduate who has had experience of general medical conditions and their management.

Health promotion: At different times staff should take the opportunity to give information on risk behaviour and how to prevent and reduce risk behaviour to the patients. All staff members should have a task in this issue, except for the manager and administrator.

Counselling & Psycho-social care: Psychological techniques have become a central part of good clinical practice of drug dependence in most countries. Clinical psychology provides models for drug dependence, combining social and neurobiological theories. For example, motivational techniques can be important in the assessment procedure in engaging drug users in treatment as well as preventing relapse during the detoxification regimen. It

is likely that the provision of psychosocial therapy in conjunction with pharmacological approaches improves outcomes, but research evidence is currently limited [11].

Personnel

A mobile community treatment team would require staff members from different fields of expertise. The exact structure of the treatment team would depend on the nature and extensiveness of the services being provided and the population being served. A case manager is available on the van; the patients can meet with the case manager confidentially to discuss their treatment needs. The clinicians would be involved in the assessment of the patients' substance use and provision of the medications. Outreach workers who are former drug abusers canvass the neighborhood locating drug abusers to educate them about risk reduction behavior, treatment and HIV/AIDS. The professional social workers and substance abuse counselors help to establish comprehensive education, counseling, and referral services in the programme. Ex-addict facilitators can be used to mobilize the other substance users to enlist in the mobile treatment programme. It is advantageous for community-based outreach workers to work in teams of two, matching former drug abusers with shorter recovery experience with staff members who have never abused drugs or who have been in recovery longer. The staff must be open-minded, professional, respectful and non-judgmental. Some research has shown that in a methadone maintenance programme where the staff can be identified as 'abstinence oriented' patients will leave quicker than when a programme is 'maintenance oriented'.

Collaboration between professionals-Teamwork

Each mobile community treatment facility must ensure that contact between the staff as well as between the staff and patients is

respectful and that there are appropriate working conditions.

Liaison with external professionals

In the setting of a community mobile treatment a liaison with the external professionals might be needed. The liaisons could range from the local primary/ community health centres, district health centres, Immunology/ HIV clinics, District Tuberculosis Centre (DTC), De addiction/drug dependence Treatment Centre for specialized in-patient/ out-patient care. The co-operation between treatment and care establishments should facilitate an appropriate and continual care of patients.

Urinalysis

Although urine analysis is a vital part of the initial medical assessment of the patient, it is often used as a form of control over patients to see if they are not continuing to use illegal drugs with their medication. The information can also be obtained by asking the patient, which would save a lot of time and money. This requires a good patient-doctor relationship which is based on respect and mutual trust. However, it is also argued that a positive urine test should never be a reason for discontinuing treatment as it is evidence of symptoms of the condition the patient is being treated for. Moreover, some of the mobile treatment programmes, because of their low threshold approach, dispense the medications in spite of the substance use status of the patient and hence, do not carry out the urine testing.

The Physical Setting

The World Health Organisation defined in 1998 that, when a treatment system is developed in any country, it should be planned as an integral part of the community's overall resources to deal with health and social problems. It should be 'population-based' [13]. A proper infrastructure will enable a professional method of working and compliance with guidelines. It needs to be decided in advance

how the available space will be allocated to provide services.

The secure and accessible space for storage of vehicle during non-working hours as well as space for the vehicle during working hours should be finalized. The choice of place for dispensing of the services should be carried out in direct consultation with the representatives from the local community. The place should be easily approachable by as many substance users as possible, and create minimal interference in the routine activities of the general population. The frequency of the visits made by the mobile van would depend on the patient load and the kind of the medication being dispensed.

The location of the programme should meet some important conditions. As patients will have to attend the programme regularly, and in many cases daily, it should be located at the area which is familiar to most of the substance users and is easily approachable. In order to avoid stigmatisation it may be important to have a neutral façade, that the sign outside says something neutral, e.g. 'health service'. It is recommended to seek contact with the local police in order to explain the importance of attracting people with a drug dependency to the programme without fear of coming into contact with the police. Agreements should be made to avoid the presence of police posting outside the centre or in the neighbourhood, which may cause panic and fear in clients.

Hours of Operation

There is no consensus regarding the most appropriate hours of operation for community-based outreach activities. Programmes differ with regard to times designated for contacting at-risk individuals in street and other community settings. Various factors such as patient population being targeted, catchment area of interest, availability of team staff should be kept in mind while deciding for the hours of service delivery. However, it is recommended that once hours of operation have been assigned,

all workers should observe them, regardless of personal preferences. Also, administrative or supervisory staff should always be on when community-based outreach workers are in the field. This would ensure that someone is always available to clarify the queries, give referral advice, and provide support for community-based outreach workers.

Maintaining contact with participants

For community-based programmes that offer multiple sessions or plan to maintain regular contact with participants, it is necessary to have a system for locating participants and reminding them of scheduled activities. For new programme participants, the community-based outreach staff should complete a detailed locator form. Telephone calls or reminder letters can be used to remind participants about any change in the dispensing schedule, if any, and to notify participants of missed appointments. If these methods to contact the patient fail then the community-based outreach workers may visit the last known address, as well as other places where the participant is known to socialize, and try to re-engage the participant in programme activities.

Recordkeeping

Clearly written or computer records of prescribing should be kept. Apart from these, a form documenting any contact of longer than 5 minutes with potential participants is recommended. The contact form should include all relevant details of each participant encounter, including the names of both the participant and the staff member, the date and time of the contact, as well as contact duration and location. The nature of the contact also should be documented, and space should be provided for recording notes. This could include documenting check-in and check-out times; tracking the number of persons referred for other services as well as those receiving social service referrals; a log of telephone/

letter contacts between community-based outreach workers and the administrative office or supervisor; and performing occasional supervisory field visits and documenting observations. A patient-held record, countersigned by those involved in care, can be a useful adjunct to treatment. Other medical staff members who may see the patient should be informed of current treatment. The information thus gathered can be discussed at regular meetings of the administrative team and thus can help to improve the functioning of the programme.

Supervision (Monitoring and Feedback)

The programme supervisor should assist and support community-based outreach workers in maintaining the consistency of intervention activities. Outreach supervisors should spend time on the streets each week with each team. Supervisors should seek to instill a sense of order in the job. They play a central role in hiring new outreach staff and defining, from the outset, the parameters of the position. The following recommended procedures can help community-based outreach workers organize their daily responsibilities and provide structure for their work (i) supervisors should meet with outreach staff at the beginning of each day to coordinate that day's activities;(ii) near the end of each day, staff and supervisors should meet again to complete paperwork; and (iii) after the paperwork is given to supervisors, a team meeting should be held.

These meetings typically centre on events that occurred during the day, but they also afford an opportunity for the staff to receive feedback and provide information to each other and the supervisor. These discussions are particularly important, since they can lead to needed modifications in the content or location of outreach efforts.

Evaluation

It is important to have checking mechanisms to see if the different professionals are doing their work adequately, and whether

individual patients who are admitted into treatment are suited for that particular type of treatment. A descriptive analysis on the basis of the monitoring of activities is always possible. The programme can have some system of monitoring its activities: how many people are seen, with what frequency, how much medication is prescribed, staff/client ratio, number of counseling sessions required to engage a client, number of referrals made to social service and drug treatment agencies etc.

Evaluation of the treatment outcome or a cost-benefit analysis can be carried out. A survey could be carried out among patients to check if they are satisfied with what is being offered and the way in which it is offered to them. Assessment of the quality of the service could be measured with more qualitative instruments, such as through a 'focus group' or in-depth interviews with workers, clients, consumer groups, neighbours, community leaders, police, etc. It can be useful to involve external experts for this type of evaluation.

The process of community mobile treatment- mobilizing the community

It is recommended that patients and their family members be involved in the development and running of treatment programme. The process of community mobilization would begin with identification of the problem. This would mean identifying the individuals within the community who are having problems due to substance use and are willing to do something about it. Raising the awareness of the community on these issues would help in accelerating the process. The aim should be to include as many personnel as possible. They should also be representative of the diverse stakeholders. Meeting of these members, sessions in the local schools, colleges, and community halls can provide the community with the required information regarding the substance use, need for treatment and the available treatment modalities. Involvement of as many individuals as possible in the

programme would provide role models for those who would still be contemplating. The active participants of the programme could also provide the support to the potential new help seekers. It would be a continuous effort of the mobile unit to harness more community participation. Service users should also be given regular opportunities to assess the services that they receive so that they could provide feedback and inputs to modify the approach. Many programmes in Europe have service-user groups who work closely with clinical staff, and such groups should have an important voice in matters of policy and practice. Such initiatives enable closer communication between patients and professionals, as well as better mutual understanding and concern. Some programmes also involve patients in the development of treatment protocols and facilitates access to patient advocacy services. The mobile task team has the responsibility to spend time to know the neighborhood and the people within the neighborhood, thereby building trust in what they are doing with prospective clients.

Impact of the ongoing programme

The Amsterdam methadone programme, with their harm reduction approach, reaches an estimated 60% to 70% of the city's 5000 opiate-dependent drug users receiving treatment. Implementation of the programme led to improvement in public order as open drug scenes were no longer tolerated in the city and a major chunk of these users shifted to mobile methadone dispensing.

Using the data from the Amsterdam Central Methadone Register (CMR), it was found that the low threshold component of the programme had significantly reduced mortality rate in the opioid users. Patients in a community-based methadone programme considered this an acceptable way of methadone service delivery and a good alternative to clinic-based treatment. Patients in the community-based programme

used significantly less heroin than before their entrance in the programme [14].

Langedam et al (1998) found that during the first year of their study on patients in methadone treatment in Amsterdam, 86% of the cohort participants received methadone at the low-threshold programme (methadone outpost, methadone bus and prostitutes' and foreigners' outpatient clinic), 10% at the medium threshold level (through general practitioners (GPs)) and 4% at the highest level, the outdoor addiction clinic [15].

The success and acceptance of the Amsterdam model can be judged by the acceptance of the model by 20 European cities through the Frankfurt Resolution to implement the low threshold model during 1990s.

Brady et al (1992) attempted to determine the feasibility and comparative effectiveness of delivering drug abuse treatment within the context of a mobile health service in the city of Baltimore [16]. The researchers compared the services provided by the medication van and a modified house trailer that makes daily rounds at several predetermined sites in a centre city community on the west side of Baltimore for drug abuse counseling along with the delivery of ancillary health services. The data regarding the programme effectiveness based on a questionnaire evaluating client satisfaction with the programme and follow-up urine samples from patients revealed that the earlier approach received higher ratings on 'convenience' and 'scheduling' items. The drop out rate is also in favour of the mobile drug abuse treatment programme as an attrition rate of only 13% has been seen with this approach as compared to rate of around 40% for the standard methadone treatment clinics in the city of Baltimore. Both process and outcome evaluations completed to date confirm the savings in time and money reflected in the patient self-reported comparisons between their previous drug abuse treatment programmes and the mobile health service drug abuse treatment

programme. Self-reported levels of legitimate employment have increased from less than 20% at intake to over 35% during the first 6-month course of treatment and comparisons with other fixed site drug abuse treatment programmes in the city. The results of this comparative analysis show that the mobile health service had a higher percentage of patients reporting daily drug use on admission; fewer previous drug abuse treatment admissions; and an average length of stay in the mobile health service treatment programme was greater than for fixed-site programmes. Greenfield et al (1996) found that the retention of patients enrolled in mobile health services (MHS), a Baltimore outpatient mobile methadone treatment programme, was for a median of 15.53 months as compared to 3.90 months for fixed-site dispensing [17].

While assessing the impact of the community mobile treatment in Anahim Lake reserve after 6 months of its inception it was seen that 75% of the service utilisers were abstinent. But for one patient all had gained employment. The improvement was also observed in the health, attendance and care at home of the school students. This was a significant change for a population whose 75% adults were having problem related to use of alcohol prior to the use of this treatment strategy.

Conclusion and Limitations

Due to the limited scope of the programme and limited resources, it would not be feasible to provide the comprehensive services to the substance users. While a set of the patients would find it suitable for their needs, others would find it short of resources for their needs. Due to the emphasis on a particular substance, other substances would not get the required interventions. The limitation of the services available through this approach to the use of opiates would mean a possible neglect of other substances being used by the individual. Moreover, while the use of illicit opiates is likely to come down by use of the

programme, the individual might substitute it with some other substance or escalate the dose of the substance being used earlier in a lesser amount. The urine sample results in the study carried out by Brady et al, 1992 showed that while there was a drop in the urine positive samples to a 40-50% level for opiates other than methadone, cocaine was found in 80-90% of the samples [16].

These issues need to be taken into account and the individuals needing interventions for substances other than opiates along with it would probably need to be referred to a setting where they can be provided with more comprehensive care. This would call for a well-planned backup and referral services. It would probably mean that the users of multiple substances would not be good candidates for such an approach.

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While evaluating the effectiveness of the programme for the opiate use problem there would be a need to assess the status of use of other substances as well.

The vicinity of the drug dispensing unit might experience increasing pressures of petty crimes and social nuisance. According to Huber, the vicinity of the area of agonist dispensing in the community experienced increasing pressure of petty crimes and social nuisance, and the “pull-effect” of the drug scene was a destructive element. Community participation in the implementation of the programme and adhering to the well-defined set of rules and work criteria would probably ameliorate such problems.

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