

**DUBLIN NORTH EAST DRUGS
TASK FORCE**

**EVALUATION
OF SPECIAL COMMUNITY
EMPLOYMENT PROGRAMMES**

**FINAL REPORT
OCTOBER 19, 2005**

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FOREWORD

This research project was commissioned by the Dublin North East Drugs Task Force to evaluate the role of current Special CE programmes in addressing the rehabilitative needs of clients in recovery, to review and examine models of rehabilitation within Special CE programmes and to assess the need to establish or extend Special CE programmes to local drug projects working with recovering problem drug users.

Special CE programmes within Dublin North East operate in very challenging circumstances and continue to be what Citywide has described as the '*central plank of rehabilitation services*' in the area.

The research found hard work, high levels of personal commitment and determined advocacy for the rights of clients, as well as high levels of frustration, indications of burnout and plain exhaustion.

The staff and volunteers on Special CE programmes and drugs projects, together with all the key informants, demonstrated high levels of expertise, deep insight and wide experience. They contributed fresh ideas, contradictory opinions, and thought-provoking perspectives about Special CE. The clients provided energy, unique insights, and at times expressed raw anger regarding their experiences in working to recover from addiction.

This work would not have been possible without the high levels of co-operation received from all key informants. People were generous with their time and experiences. Special thanks go to the clients, staff and volunteers of the Special CE programmes. Thanks also to the Treatment and Rehabilitation Subgroup, which worked closely with the researcher to develop the research and monitor its

progression. Special thanks go to Cepta Dowling of the Northside Partnership, who acted as the research liaison person, and to Vanessa Hoare of the Dublin North East Drugs Task Force, who provided invaluable support. Best wishes go to the newly appointed Co-ordinator of the Task Force, Tom O'Brien, whose job it will be to implement the findings.

Reading the report

After initial consultations in the research process, confidentiality protocols were agreed with the Special CE programmes. It was agreed that all information directly relating to the individual projects and their operations would remain within the project, and that the research would collate the findings into the general report, rather than make individual observations or recommendations on each project.

This means that observations made relate to practice in general and do not relate to practice within any individual Special CE programme. Where recommendations are made, for example in relation to the provision of external support and supervision for staff members, it is the case that some projects already have this in place. Nevertheless, this finding is being cited as good practice, and hence a recommendation is being made that it should constitute a common standard across all projects.

Equally, any difficulties working with other agencies cited in the research findings do not apply uniformly across all four Special CE projects. Indeed, one of the features of the research findings is the marked difference in interagency relationships within and between projects.

In addition, where recommendations are made to improve practice - for example to increase the use of small group work and individual class plans - it is accepted that projects that do not already have this in place are aware of the need but are resource-restricted from implementing the changes. This reflects the enormous amount of good work being done in very difficult circumstances at local level.

Research overview

The research is an attempt to bring together a range of diverse opinions and experiences - client, support worker, volunteer, funder, community representative and service provider - across the entire Dublin North East Drugs Task Force. There are a wide range of different perspectives contained within the research findings and a range of conflicting opinions within and across the four Special CE programmes and other drugs projects in the area.

The recommendations and framework for best practice presented are drawn from the learning, experience and insight of the Drugs Task Force stakeholders and other key informants. It is understood that many of the ideas have been presented before, but this is the first attempt to bring them together.

The research findings highlight how recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment and rehabilitation. Effective interventions are those that attend to the multiple needs of the individual client.

No single treatment or rehabilitation approach is appropriate for all individuals, and no one agency, in isolation, has the expertise to carry out effective all-encompassing rehabilitation and re/integration interventions.

Rehabilitation and re/integration must be placed in an interagency framework within a continuum of care model. They require commonly agreed standards of best practice together with interagency protocols and clear funding. They also require the political will to make them happen.

The research findings demonstrate very mixed views on the role of Special CE and its appropriateness as a mechanism for working with people in recovery from addiction. However, there is little confidence that meaningful alternatives exist. The majority of respondents believe that, as part of an interagency framework, and with its shortfalls addressed and good practice consolidated, a restructured Special CE model can play a central role in working with problem drug users.

This research report does not represent the end of a process, but rather the beginning. It clearly identifies the need for additional funding and development supports if Special CE programmes are to be enabled to act on the findings. The focus now is on how to implement the research findings for the benefit of all those in the Dublin North East Drugs Task Force.

The recommendations range from simple, easily achieved steps towards better practice, to ambitious steps that would require changes in policy direction at a national level and sustained work to oversee them. The model itself is ambitious in its scope and objective.

However, it is clear that the current situation cannot continue. Communities are disillusioned, project staff are stymied and clients are frustrated in their efforts at rehabilitation and re/integration.

To paraphrase Arnold Bennett, optimism, when you get used to it, is just as agreeable as pessimism.

Kerry Lawless
Equality Works!

TERMINOLOGY AND DEFINITIONS USED

The following terms and definitions have been used in the report. They reflect the terminology most commonly used by the research informants and/or those with which the researcher is most familiar.

Addiction and **dependency** are used interchangeably. No distinction is made between psychological and physical addiction.

Individuals participating on Special CE programmes for rehabilitative purpose are referred to as **clients**.

Family of origin is used to describe a client's parent/s and/or siblings.

Problem drug user is used to describe individuals with addiction/dependency issues.

The terms **problem drug use/r** and **problematic drug use** are used to describe the situation when a person's drug use has serious consequences in relation to their health, their psychological state, their social relationships, their capacity to work or study, to take care of their dependants, their involvement with crime, their ability to partake in society at a level that most others rightly take for granted.

Rehabilitation and **drug rehabilitation** are used interchangeably.

Re/integration is used to convey both integration and reintegration, whichever applies to individual clients.

Special CE programmes are also referred to as **Special CE**. While some clients use the term "rehab" CE, Special CE was most common. Participants on Special CE who are part of the 25 per cent worker ratio are described as **support workers** or **CE support workers**, the term most commonly used by projects and staff themselves.

RESEARCH FINDINGS SUMMARY

Developing Shared Understandings

Shared understandings are very often underlying principles - the aspirations by which our work is measured. Here, they point to the fundamentals of work with problem drug users at local level. Reaching agreement is in itself not the most important goal. Rather, we must find room to accommodate our differences and use them to review what we set out to do and what is actually being achieved.

Rehabilitation

The research clearly sets out the key elements and parameters of rehabilitation and places them firmly in a socio model, rather than a purely medical one.

Drug rehabilitation is seen as the development of new personal skills and structures through providing individuals with access to the necessary supports and opportunities for change.

Respondents stressed that rehabilitation does not follow a linear pattern, that it must remain open-ended and that no one size fits all.

Practical skills were cited, but for the most part only as part of an overall framework for rehabilitation. Skill development is viewed as being part and parcel of developing confidence, of capacity building, as well as acquiring practical, marketable skills.

Re/integration

Re/integration is seen as primarily representing social re/integration, not re/integration into the open labour market. Where labour market re/integration is cited, it is seen as a later stage, and as just one means of achieving overall re/integration within society.

Re/integration is seen as contingent on the extent of drug use and the extent of damage caused by drug use. It is multi-faceted and based on individual needs and circumstances.

Re/integration is described as taking place through small steps. Most suggest that progress in re/integration is best achieved through care planning, where re/integration needs are agreed with clients, and worked towards.

Progression

The survey findings demonstrated a clear understanding of the slow, incremental nature of progression in a rehabilitative context. There was also strong support for progression to be seen in terms other than progression to the open labour market. Just as re/integration was seen primarily in terms of social re/integration, progression was perceived as personal progression rather than progress to employment.

Achieving stability

Being stable means having a '*purpose to life*', '*being a productive member of society*' and '*having a place in society*'. For many this means being in education or employment, for others it means being positively occupied or being able to access mainstream services.

Of primary importance to respondents was a client's ability to look after themselves, their health, and their children. There was also a strong recognition that stability means '*taking care of business*'; dealing with any additional

outstanding issues such as housing, health, or justice in a timely and constructive manner. There was also agreement that stability means '*doing the small things*', '*eating properly*', '*collecting the children from school*', '*paying bills*'.

To sum up the research findings illustrate how being independent and overcoming dependency is seen as vital to achieving stability.

“Drug free” living

The research findings show that there is no shared understanding of what it means to be “drug free”.

Many respondents feel that definitions of “drug free” living must look at drug use in Irish society as a whole, taking into account prevalent attitudes to alcohol and drugs, be they prescription or illegal drugs. Many believe that injecting opiate users should be assessed by the same standard as the whole population when it comes to defining “drug free” living.

The research findings show a very ***slight*** majority supporting the definition of “drug free” as being '*not compromised or controlled by drug use*' with the next biggest grouping seeing “drug free” as '*being free of “street” drugs and their associated lifestyle*'. There was a much lower level of support for an abstinence definition.

Many respondents view rehabilitation in terms of being stabilised on Methadone; others, particularly those with personal experience of addiction, make a clear distinction between being “dry and sober” or “clean but crazy” - meaning that being free from opiates is, for them, just one part of the equation.

With the changing environment of problem drug use and increasing poly-drug use it is hard to assess when a problem drug user is “active”, “non active” or “in hibernation” if we rely solely on clinical assessments.

In conclusion the research findings show that respondents believe the effective monitoring of problematic drug use should focus on the dependency, not the drug.

SPECIAL CE ROLES AND EXPECTATIONS

The findings demonstrate very mixed views on the role of the current model of Special CE and its appropriateness as a mechanism for working with people requiring drug rehabilitation.

Most of the respondents were aware of Community Employment's role as a labour market intervention, but believed that the ethos of local drugs projects with specially designated CE places is one focussed on personal development and supports to drug rehabilitation rather than progression to the open labour market.

How Special CE is perceived

The research findings clearly show that Special CE programmes have been and continue to be the central plank of rehabilitation services at local level. A huge range of excellent work is carried out and the programmes make a real contribution to clients' lives, working, for the most part, in very limited circumstances.

Nevertheless, there is a strong sense that Special CE, in its present structure and as it currently operates, is failing to meet the needs of clients and is not providing adequate drug rehabilitation or any long-term solutions. Moreover, there is also a strong suggestion that, through its structural make-up, Special CE is trapping clients and by extension the community in a cul de sac of non-progression.

How effective is Special CE?

The survey results on the effectiveness of Special CE were very mixed and at times contradictory.

The majority of concerns raised centred on issues such as premises, facilities, staffing levels and qualifications - and a perceived lack of accountability within Special CE programmes - rather than on the role of FAS itself or the work of the projects. Many of the concerns relate to Community Employment as a whole and are not exclusive to Special CE. For example, criticisms of Special CE and how it interacts with social welfare payments pre-date the special designation and ring-fencing of places and are inherent in the operation of Community Employment itself.

Not surprisingly, respondents who have knowledge of the more structured Special CE programmes, where the ratio of qualified staff to clients is adequate, premises are more suitable and where there are positive, cooperative, working relationships with the treatment clinics, were more likely to be in favour of maintaining Special CE within an interagency rehabilitation framework.

Where does the problem lie?

The lack of comprehensive treatment and a re/integration framework poses huge difficulties. As one respondent described it, Special CE is, for most problem drug users, *'all there is: without CE they have nothing'*. This places enormous pressure on projects *'to meet each and every need'*, and leads to unrealistic expectation of what Special CE is, or should be.

All respondents believe that the current model of Special CE as a whole is too loose, lacks the appropriate structures and staffing levels, and is too isolated from other rehabilitation routes. Respondents believe it is too insular looking, and that there is too much duplication between the work of the Special CE programmes, in terms of advocacy and support services, and other agencies.

Furthermore, respondents also believe that the success or otherwise of Special CE within Dublin North East is too dependent on the commitment and expertise of individual staff or Sponsor members and that it needs to be placed in an interagency rehabilitation framework.

There was a strong sense of frustration that there are few suitable progression routes available to Special CE clients. The length of the existing programme was cited as the main reason for this. Many respondents strongly believe that three years is simply not long enough to deal with the range of issues clients present with **and** to support them in becoming work ready.

The future focus of Special CE

When asked what the focus of Special CE should be, the vast majority of respondents stated that it should continue delivering a mix of services, rooted in a strengthened therapeutic environment, and dealing with a range of interconnected issues. Strong support for client re/integration is evident, with a particular emphasis on health, social services, housing and counselling. Clearly, the majority of respondents view Special CE primarily as a mechanism to support drug rehabilitation.

Most respondents believe that Special CE **should** have a therapeutic function as its primary role. Second to this, they believe, is the role of advice and support. Education and training was, they considered, least important of the three. Even the minority of respondents who believed that Special CE should focus solely on education and training viewed therapeutic and advocacy functions as being central to its effective operation.

It is recognised that these changes cannot happen within the current premises, and in the context of present facilities, staffing levels and qualification levels in Special CE programmes. Major policy change at national level would also be required to implement the changes, respondents believe, and this would need to be matched by an increased commitment to working to common standards at Task Force level.

From Special CE to a re/integration programme

In terms of the best way forward, as outlined earlier, there is a clear distinction between those who believe that CE is wholly unsuitable for drug rehabilitation work and those who believe that - with further adaptation - Special CE can work effectively.

For those respondents who believe Special CE programmes can be supported to work more effectively, it is agreed that this will only happen if the work of the projects is restructured and placed within an interagency framework. Many respondents see this as the best way to channel the experience and expertise accumulated within the community to meet clients' multiple needs.

Many believe that better policy and practice on assessment, progression indicators and referral, together with the development of pre-CE programmes, would address many of the issues within Special CE.

The crux of the issue is not *whether* Special CE is or is not the appropriate mechanism for drug rehabilitation - it is agreed that it is not - but *how* best to meet the rehabilitative, educational and work orientation needs of the clients.

Recognising realities

The fact is that Special CE is established. High levels of demand remain for Special CE places and few alternatives exist. The 2004 Bruce Review confirms that, for many participants, Community Employment is a key element in stabilising their daily activities.

Huge levels of learning have taken place within Special CE, and its structures are established at community level. Any new programme put in place would have to include all the key elements contained within Special CE and address the shortfalls and limitations highlighted in this and other research.

As such, Special CE is well-positioned to be redeveloped into a more cohesive rehabilitation and re/integration programme. The challenge is to locate the best practice it has developed and adapt it to an interagency re/integration framework within a continuum of care model. This requires commonly agreed standards of best practice, together with interagency protocols. It also requires the funding and political will to make it happen.

Expanding Special CE programmes

There is a clear demand for additional Special CE places, in spite of community and project reservations regarding the programme's operation. Those respondents who are active outside the catchment area of existing CE programmes maintain that there is unmet demand in their communities for the establishment of rehabilitative and re/integration programmes. Howth and Bonnybrook/Fairfield/Riverside, in particular, are aware of a strong demand for Special CE within their areas.

Any new Special CE programmes or re/integration programmes developed must gain from the learning of the existing projects. They must be developed in an interagency context, addressing the limitations of the current programme and building on its best practice.

In particular, guidelines for staffing ratios and qualifications, counselling roles, and minimum standards for premises would need to be in place. The work would need to be based around a service agreement with funders and agreed within an interagency framework.

Expanding Special CE programmes in new Task Force areas presents an opportunity to develop more of an interagency and supported approach to re/integrations.

Developing a re/integration model of Special CE in areas such as Howth or Bonnybrook/Fairfield/Riverside could provide the opportunity to implement many of the research finding recommendations and pilot new practice. It could act as a demonstration model of what the Special CE model can achieve when all the necessary supports and structures are in place.

INTERAGENCY WORKING

The need for an interagency approach

All respondents cited the lack of interagency approaches as one of the main barriers to the full effectiveness of Special CE and indeed to any work with problem drug users.

While many of the respondents spoke of good personal relationships across organisations and cases of strong individual co-operation between agencies, there is a clear absence of systematic interagency work.

Day to day within Special CE programmes the absence of interagency co-operation creates difficulties. The research has shown how very often, as is the case with secondary social welfare benefits, the interaction of CE with other entitlements leads to a loss of income supports. The discretionary nature of the decisions and the lack of an interagency forum to raise the issues for individual clients mean that clients and key workers are stuck in a merry-go-round of agency interaction trying to positively resolve the issue.

Priority areas for co-operation

Drug treatment was clearly identified by the research findings as the primary area where interagency work is required. While the feedback was highly critical of present practices, provoking strong feelings and stark differences of opinion, it is clear that respondents are united in their desire for improved approaches to treatment co-operation.

Housing, social services, education and justice were also named as key areas where interagency work is essential.

Current issues in interagency work

The research clearly demonstrates that more needs to be done to foster positive working relationships at organisational level.

The lack of clarity within the HSE about the roles and functions of each area of work was criticised as adding to the lack of interagency co-operation for clients.

Equally, community organisations and projects themselves were criticised for failing to work co-operatively with other agencies. Territorial concerns and intra-project rivalries are perceived as diverting energy from projects and hampering the progress of clients.

There were also calls for what one respondent described as '*honest conversations*' between projects, funders and service providers about roles and responsibilities leading to increased transparency and accountability.

There were calls for the Drugs Task Force to take a greater role in co-ordinating certain elements of the programme's work, such as facilitating an annualised staff training programme, developing interagency protocols and policies, and securing funding for core supports.

Making interagency work happen

It is clear that an interagency forum is needed to case manage issues and priorities based on a client's individual care plan. It is also evident that structures and policies need to be put in place to clarify exactly where individual agency roles and responsibilities lie and to determine which agency is the lead agency for which issue. The role of brokerage within this system needs to be clarified and agreed.

Respondents believe that greater community awareness around how agencies work is needed, in order for interagency co-operation to work well. It is believed that the establishment of working relationships is as important as the development of new work practices.

Who should lead rehabilitation and re/integration programmes?

A majority of respondents believe drug rehabilitation projects should, in theory, be the responsibility of the HSE, and that FAS is not equipped to be the lead agency.

Conversely respondents were also equally, if not more, critical of the role of the HSE. The HSE is perceived as having abdicated responsibility, failing to develop cohesive programmes and policies, and reluctant to commit the level of resources and commitment that FAS has invested in the projects.

Many believe that '*community groups are out of their depth*' in what they are attempting to achieve with Special CE.

The majority of respondents believe that Special CE should not be the responsibility of any one agency with some respondents suggesting it should be led by an interagency team directed by a National Rehabilitation Agency.

It is clear that no one agency has the expertise or structures to deliver effective and sustainable rehabilitation and re/integration programmes in isolation. No single model of recovery and re/integration can suit all individuals.

Specific burdens regarding childcare, allowances, housing, health and imprisonment complicate personal goal setting. Many Special CE clients are exceptionally marginalised and disempowered with profound feelings of worthlessness and exclusion. Personal care plans are needed for individuals to advance. However, they cannot be delivered on in isolation within Special CE programmes. This is by its very nature multi-agency.

There are good models of interagency work to draw from. The Blanchardstown Equal Initiative - which lead to the development of common protocols by agencies working with drug users and former drug users - is one good example.

Dublin North East needs to build on good practice already established to make interagency working a reality.

FROM SHARED UNDERSTANDINGS TO PRACTICE

Protocols and procedures

The research findings produced a wide range of data on the concepts of rehabilitation, re/integration, progression, and stability. At its heart was a shared aspiration for clients' recovery and re/integration.

There was strong demand for protocols around assessment, progress indicators, and referrals.

It is evident that any discussion of progression is meaningless unless we are aware of the clients' ***starting point***, as well as their final goal.

The shared understanding captured in the research can act as the starting point for the development of commonly agreed protocols and procedures. The feedback and agreed criteria to date is provided in full in the appendices. While not definitive, it is expected to form the basis of commonly agreed standards of assessments as part of a system of interagency protocols.

Such common agreement requires interagency protocols on key issues of assessment, progression, referral and confidentiality, as outlined previously. It also requires agreed common standards for staffing levels and qualifications, programme components, counselling services, premises and other essential factors in the effectiveness of Special CE.

Assessments

There was widespread agreement on the range of issues that need to be addressed as part of a client's re/integration and as to what factors constitute a stable lifestyle. These can be put into practice to reflect the main areas required in effective assessments procedures and are listed in the appendices. While not definitive, it is expected that these agreed definitions will form the basis of commonly agreed standards of assessments, as part of an overall system of interagency protocols.

Progression

The survey findings demonstrated a clear understanding of the slow, incremental nature of progression in a rehabilitative context. There was also strong support for progression to be seen in terms other than progression to the open labour market. Just as re/integration was seen primarily in terms of social re/integration, progression was perceived as personal progression rather than progress to employment.

Bruce (2004) found that the wide variety of understandings and definitions around progression in Special CE programmes made any meaningful comparison impossible. Nevertheless, this research - through its ongoing collaborative approach - has been able to identify commonly accepted indicators of progression.

These indicators range from development of social skills, such as interpersonal skills and the ability to take part in educational activities, to indicators of improved work routine and increased education. Indicators of harm minimisation and relapse prevention strategies are also cited, together with improved external and significant relationships. Work and further education orientation were considered major components of progression benchmarks, although such developments, it was stressed, should be viewed as part of the final stages of Special CE.

The central role of the initial client assessment and the need for a uniform standard of policy and practice were also identified by the research. Progression is meaningless, it was suggested, unless we know where the person is progressing **from** and where they hope to progress **to**.

Referrals

Key factors that impact upon interagency referrals were developed for the research findings. Existing best practice outside of Dublin North East was also explored and is outlined in the appendices. With further consultation, it is expected that this will form the basis of commonly agreed standards of referrals.

This is true of both referrals **to** and **from** Special CE programmes. In regard to referrals **to** Special CE, there is a clear need for an agreed number of referral points to be developed. These would facilitate clients in accessing Special CE from a number of starting points, including GPs, counsellors, the Rehabilitation and Integration Service and other key stakeholders. However, such a system must be restricted to an agreed number and range of referral points. It must also be supported by the development of policies and procedures that support Special CE programmes in dealing with any additional workload incurred, and support clients in meeting their particular requirements.

STAFFING ISSUES

The initial findings produced a wide range of responses on staffing arrangements within Special CE programmes, highlighting serious concerns about present staffing ratios and what is perceived as an over-reliance on CE support workers for highly skilled and challenging work.

There are also concerns about the working conditions of CE support workers, the lack of a cohesive approach to training, poor pay in relation to the challenging roles and responsibilities involved, and weak progression rates.

Limits of current staffing structures

The research findings demonstrate that work on Special CE programmes is highly skilled, personally demanding, and intensive. It requires a mixture of personal aptitude, practical experience, proven core competencies and formal qualifications to work effectively and safely with clients.

Staffing arrangements vary considerably from Special CE programme to Special CE programme. Some projects have developed well-balanced staff-to-client ratios, and a strong ratio of highly qualified, experienced staff to those staff in training. Supervisors have invested considerable time and energy in developing their own skills and those of their staff, and are well aware of the issues involved.

Nevertheless, there was unanimous agreement that the existing system in those projects - with a heavy reliance on CE support staff - is unfair, on both the clients and support workers involved.

Priority issues identified

Staffing roles

The work of Special CE involves a range of one-to-one work, key working and interventions. The ratio of qualified staff to clients needs to be significantly increased to reflect this, and core funding needs to be put in place to ensure its implementation.

The roles and responsibilities of all staff need clarification. A common grade system, salary scale and set of job descriptions needs to be established and must reflect the roles and responsibilities of all Special CE programme staff. In particular, the role of key workers needs to be clarified - with minimum training, qualifications, and practical experience levels defined and agreed for the role.

Evolving role of CE Support Workers

Some respondents see the position of CE support workers as the exploitation of staff who are carrying out professional roles on CE wages. There are calls for some kind of bonus system of additional payments to be put in place.

There is also a sense of frustration that the very structure of CE means that CE support workers leave the programme just at a time when they have developed high levels of professional competency. Equally, CE support workers are frustrated at the lack of career progression when they have completed their Community Employment. Many reported having to retrain or to return to employment that does not utilise the skills and experience they have developed within Special CE.

The role of CE support workers needs a total overhaul. The position must move to one of a trainee or work placement position within the context of a high-level annualised and accredited training plan with appropriate professional salary scales.

SERVICES AND FACILITIES

On site facilities

Kitchen facilities are seen as essential to the work of Special CE programmes. Every respondent agreed that kitchen facilities provide opportunities for increased nutrition, life skills and health management.

There is also strong support for the provision of **showers and washing machines** as part of the Special CE infrastructure.

The provision of onsite **gym facilities** had strong support among clients, but other stakeholders believe that, as a resource, it would be too difficult to maintain and that instead clients should be supported to access gym facilities in their own locality.

There were mixed levels of support for Special CE programmes to have dedicated **information technology facilities**. Where the premises are multifunctional and have a range of community interests involved, it makes financial sense for the IT facilities to be onsite.

Core services

Calls were made for **primary health care** to be provided within the treatment clinics. It is seen as essential that clients have ongoing and ready access to a full range of medical interventions related to their problem drug use.

Counselling is a key element of rehabilitation and re/integration programmes. All respondents cited the availability of counselling as a key part of Special CE programmes.

Counselling must be provided by fully qualified and experienced counsellors. A panel of counsellors needs to include counsellors with a range of specific skills training and expertise, particularly in the areas of abuse, sexual assault, prostitution, sexual orientation and family systems.

Community based services

Childcare provision is considered essential and it was seen as important that it should **not** be provided within the same location as the Special CE programmes.

Childcare is needed on Special CE for all child dependants - pre-school and school going. It is essential that the programmes make provision for childcare during school holidays and for school in-service training days.

Strong support was expressed for the provision of **drop-in** facilities as part of any re/integration programme. However, it was seen as essential that they are kept physically separate from the Special CE programme and also that they maintain a separate ethos and structure.

Keen backing for the provision of **aftercare**, as part of the “move on” element of re/integration programmes, was also evident. It was considered essential that any aftercare service operate with flexible hours, to enable access by clients in the workforce or further education.

Out of hours services, particularly weekend provision were also in strong demand from clients, as well as alternative **social activities**.

Peer support, too, was viewed as a necessity. For most respondents, peer support outside of the Special CE programme has been Narcotics Anonymous (NA), which has met with mixed results. It is seen as an essential pillar of aftercare and it is important that opportunities for safe, structured peer support are developed.

Respite services and **community-based detox facilities** were seen as crucial to the rehabilitation infrastructure of Dublin North East. Further work is required to ascertain what steps need to be taken to establish these facilities.

Premises

The quality and size of the premises where Special CE programmes are delivered is a source of deep frustration for clients.

Rehabilitation and re/integration should take place in a **calm and relaxed environment**, with space and scope for the range of work and activities that take place within Special CE programmes. Crowded, noisy and cramped premises are not conducive to intense therapeutic and developmental work.

EMERGING ISSUES

Methadone: a stalled project?

The research survey captured a range of views about methadone use.

There are major concerns about the administration of the Methadone Programme. There is also a deep unease about the over-reliance on methadone treatment and the absence of a comprehensive treatment infrastructure.

For some, methadone has worked and continues to work, changing the lives of individual clients in spite of the problems in how it is administered. For others, methadone is seen as a form of social control and as a publicly funded addiction programme, an abdication of the state's responsibility and a real and present danger to our communities.

However, most would describe it as a '*stalled project*'. Rather than have methadone play a part in the initial stages of stabilisation and treatment, it has, more often than not, become the sole and final solution. The "one size fits all" approach is criticised and seen as failing clients. In this analysis, the problem is not with methadone use *per se*, but with the lack of comprehensive, locally delivered treatment options.

Treatment and catchment areas

Community representatives are very aware of the demands to open up rehabilitation facilities beyond the existing catchment areas. There is resentment that communities in surrounding areas, who did not march or lobby for treatment, are now seeking to avail of the services developed within the communities that did.

Other communities are perceived as being resistant to the reality that they have a problem, preferring to have it dealt with elsewhere.

There is a recognition that communities who did agree to treatment facilities were in some cases given very strong guarantees as to what that would involve and who it would serve.

Special CE and catchment areas

Clients clearly stated a desire for flexibility in the catchment area criteria for participation on Special CE. The delivery of locally based supports is seen as essential. However, for some clients at different stages in their recovery, there is a need to break away from their familiar peer group setting.

There are also occasions where accessing one's local projects is neither possible nor desirable. This is particularly true when clients and staff are related or very well known to each other. In addition, while based on best practice, the policy of some of the Special CE programmes not to allow siblings into the same group at the same time limits potential client participation.

It is believed that, if separated from the treatment issues and restricted to those communities that have Special CE in place, it is possible to **both** assuage community fears and meet the needs of clients who wish to access Special CE outside their local area. This could be based on a limited pairing system within **existing** Special CE programmes to allow local people find the best place for their participation on Special CE.

Legal Issues

Criminal convictions and employment

The research findings show strong support for a formal system of expunging the criminal records of problem drug users who can demonstrate that they have rehabilitated, in order to remove barriers to accessing employment. It is understood that this would need to be managed in such a way as to reassure employers, and also to screen those with convictions for violence and/or offences against the person.

Drug driving

Major concerns have been raised about the appropriateness of projects providing driving lessons and encouraging clients on methadone to apply for driving licences.

On the one hand, the law would appear to take a totally prohibitive stance with the charge of drunk driving applying to anyone with methadone in his/her system. On the other hand, as a prescribed medication, doctors would appear to be in a position to determine if methadone levels would interfere with the ability to drive.

Whether methadone use invalidates car insurance is an issue that has also been raised.

Whether driving lessons, and the costly activity of forklift driving in particular, actually lead to employment opportunities for clients, has been put into question.

Specialist counselling services

Sexual assault, rape and childhood abuse

There is an acute shortage of fully qualified specialist counsellors available to clients in the Special CE programmes.

Many of the clients are working with counsellors who are in the process of receiving their accreditation and may not have specialist training in the area, or sufficient experience. Clients also raised the issue that dependence on volunteer counsellors or those working up their hours makes it hard to guarantee the long-term working relationship necessary to deal with issues such as childhood abuse.

The research demonstrated huge levels of concern about the inadequacy of Special CE responses as a whole. Staff spoke of being out of their depth, of not having sufficient supports to deal with disclosure. Other respondents raised concerns about inappropriate interventions and the possible long-term damage this can do to clients.

There is an urgent need for counselling within Special CE to be funded and for quality assurance standards to be put in place at Task Force level, to ensure that clients have access to the range of specialist and long-term counselling supports needed.

Sexual exploitation and prostitution

Respondents report clients as having experienced high levels of sexual exploitation and of many of the women and men having been engaged in prostitution as a means of supporting their addiction.

There is evidence of high levels of “swapping” among young people, that is, the exchange of sex for alcohol or drugs, a recognised progression path to more overt forms of prostitution.

Active problem drug users in contact with services are known to be involved in prostitution.

Staff spoke about the high levels of disclosure of prostitution and a lack of understanding of how best to proceed or to deal with the issue.

There is no clear understanding of what is involved in prostitution and how it is a process in and of itself from which clients need to recover.

Homelessness

A number of the Special CE clients are, or have been, homeless. Accommodation issues were cited as one of the clients' major concerns, with many perceived as being at risk of homelessness.

There is a large homeless population living in and around Howth, sleeping rough in the woods and on empty boats. This highlights the need for homelessness facilities in the area.

More work is needed at Drugs Task Force level to determine the prevalence of homelessness, to lobby for facilities to be put in place and for services to be expanded to Dublin North East.

The needs of methadone patients in full-time education, training or work

Those clients who do progress face problems in accessing the clinic at a time that accommodates their needs. This is especially true of fishermen and others who work irregular hours, but it is also true of those working 9-5 within Dublin North East. They report major hurdles in accessing treatment without interfering with their jobs.

CHAPTER 1

DEVELOPING A SHARED UNDERSTANDING

The survey process set out to explore shared understandings of key concepts underpinning the work of the Special CE programmes.

It attempted to see how the different interpretations of the concepts of rehabilitation, re/integration, progression, stability, and what is meant by the term “drug free living”, impact on the work of Special CE. Through the initial consultations and formal survey, the research explored what these concepts mean in practice and how respondents believe they can be measured and assessed.

The findings demonstrate the rich array of experience and expertise within Dublin North East. A broad range of responses were collated highlighting the wide disparity of views, at times conflicting, on the role of Special CE in rehabilitation, among Drugs Task Force stakeholders and the research’s key informants.

Shared understandings are very often underlying principles, the aspirations by which our work is measured. Here, they point to the fundamentals of work with problem drug users at local level. Reaching agreement of itself is not the most important goal. Rather, it is finding room to accommodate our differences and use them to review what we set out to do and what is actually being achieved, that is most important.

Terminology

Some respondents had problems with the terminology reflected in the questionnaire, seeing the word rehabilitation as too medical, too negative, and too closely associated with physical rehabilitation rather than recovery from problem drug use.

Others believe that the term rehabilitation simply denotes a return to something, “to be restored to former use”, whereas many of the clients of Special CE want to do more than just return to their pre-drug-using circumstances.

Respondents were equally concerned about the “re” in reintegration, citing how many clients feel they were never integrated within society in the first place, and that their participation on Community Employment represents their first attempt. One respondent objected to the term “drug misuser”, believing that the term “drug user” was more neutral and more reflective of the reality of problem drug use.

Some respondents didn’t believe they were qualified to provide definitions, preferring it to be left to those respondents who deal with problem drug users as part of their daily work. Moreover, others still believe that it is the work of the National Advisory Committee on Drugs to define rehabilitation and the other key concepts underpinning work in this area.

Rehabilitation

The research used the key elements of rehabilitation identified by the Dublin North East Drugs Task Force Working Group on Rehabilitation Policy and Strategic Development in 1999 as a starting point for the survey.

The findings clearly show that, in the main, those key elements identified still hold true and reflect the experience and aspirations of those working with problem drug users.

The research survey produced a broad, far-reaching range of responses on what is understood by the term “rehabilitation”. The majority see drug rehabilitation in terms of the development of new personal skills and structures through providing individuals with access to the necessary supports and opportunities for change.

When asked to rank the key elements in relation to the work of Special CE programmes in Dublin North East, the vast majority of respondents focussed on the same four key elements:

Development of personal structures/skills to enable a drug-free lifestyle
Recognition of individual needs in rehabilitation
Availability of counselling services
Learning of new skills to enhance life

The '*development of personal structures/skills to enable a drug free lifestyle*' was the element most cited by respondents as the core tenet of rehabilitation. It is felt that with the skills and structures all other work relating to recovery will follow.

Respondents believe very strongly that problem drug users can only be facilitated to develop the necessary skills and structures for recovery through '*the recognition of individual needs in rehabilitation*'. Care plans, which reflect individual needs, are seen as being central to drug rehabilitation. There is also considerable support for projects to move away from the predominantly large group setting of work with clients to more individual classes and small group work. Many respondents said eight participants in any group setting was the maximum number that would work effectively.

The '*availability of counselling services*' was ranked as one of the top three elements of rehabilitation. It is accepted that counselling does not work for everyone and that clients will require different levels of support at different stages. Still, the availability and option of counselling was seen as critical to long-term sustainable recovery from drug dependency. Here the availability of counselling is described as the provision of one-to-one counselling outside of the HSE system of clinic counsellors, and drawing on a range of specialist supports as required.

A final key element identified was '*the learning of new skills to enhance life*'. Here respondents cited a range of skills, from communication and parenting skills, to relapse prevention and health management skills.

Practical skills were cited, but for the most part only as part of an overall framework for rehabilitation. Skill development is viewed as being part and parcel of developing confidence, of capacity building as well as of acquiring practical, marketable skills.

Access to employment was also mentioned, but as part of the overall rehabilitation and re/integration framework, rather than as a primary goal.

Other elements of rehabilitation

Respondents named a range of other elements of rehabilitation, which are listed in full in the appendices.

They focus on the need for a safe, secure place where clients can *belong*, free from judgment, to a place where the client's drug dependent behaviour will be challenged. Special CE programmes were cited as a good example of this.

Rehabilitation can only take place if clients are provided with access to a full range of supports and activities, from harm minimisation to improved nutrition and alternative social activities.

The work of the Special CE programmes was seen, by a majority of respondents, as playing a central role in rehabilitation. It is seen as facilitating clients in addressing outstanding issues, from health to housing and justice, to repairing damaged relationships with family members and the community. Conversely, respondents also questioned the appropriateness of Special CE taking responsibility for this work. These findings are further explored in the chapter *Special CE: Roles and Expectations*.

Care planning was seen as central to rehabilitation, with respondents citing the need for clients to set goals and measure their own recovery in achievable milestones. Care planning also recognises that drug rehabilitation is a process of change and that it can represent different priorities to clients at different stages of their recovery. The research clearly found that care planning is at the centre of the work of Special CE.

Respondents also noted that gender issues must be taken into account and different issues can arise for both men and women, requiring different responses that must be addressed separately. Special CE programmes that operate women-only or men-only sessions report that they are highly successful and facilitate clients in dealing more effectively with gender specific issues or client concerns that may arise. The majority of respondents also believe that rehabilitation must take the entire family into account and needs to be underpinned by a whole-family approach from the outset.

Clearly, there is a range of factors at play for individuals dealing with addiction. There is also strong recognition of the long-term process of change involved in drug rehabilitation; a process that does not follow a linear pattern, but must remain open-ended.

Rehabilitation and Special CE

Some respondents saw rehabilitation as beyond the work of what the specially designated places within Community Employment were set up to achieve. This is discussed in more detail in the chapter *Special CE: Roles and Expectations*.

Many respondents believe that the first step in working with problem drug users is to get the drug use under control and to support them in bringing some stability to their lives. These respondents see the second step as dealing with ancillary issues such as health, housing, and justice, and that only then can rehabilitation take place. It is believed that education and training inputs belong at the end of that process. The point was made that training can not take on a rehabilitative function if the client remains addicted.

However, a majority of respondents see that such a staged approach does not reflect the realities of the lives of problem drug users. For example, clients can be faced with a housing crisis at any stage in their recovery.

Due to such considerations, respondents believe that only a holistic approach to rehabilitation, starting from where the client is, will lead to sustainable positive change. Respondents believe that, with structural change, modifications and within an interagency framework, the Special CE model remains best placed to support the rehabilitation of problem drug users.

Special CE was cited as a good example of how clients can be provided with a safe place of engagement free from judgment. The fact that Special CE provides clients with a structure and routine together with, for most, an improved income, means it is a source of pride and status.

Clients describe how simply *'getting up and coming into the job'* [Special CE] provides them with status within their own communities. The majority of respondents focused on this aspect of rehabilitation, the re/claiming of dignity - being able to *'walk tall'* - as central to recovery. In this respect, rehabilitation is described as being *'about overcoming dependency and re/gaining a capacity for daily life'*.

Several respondents cited the Irish Association of Rehabilitation Professionals' definition of rehabilitation as a good example. This definition sees rehabilitation as a *'facilitative process involving individuals who are disadvantaged in terms of accessing life in the mainstream. The rehabilitation process aims to enable individuals to access as independent a life as possible in social, cultural and economic terms, which is congruent with their aspirations'*.

Other respondents saw rehabilitation as simply being drug free, meaning, for the most part, on methadone. For others, rehabilitation was about dealing with the issues that led to the problem drug use and addiction. The majority of respondents made a clear distinction between medical and social rehabilitation, favouring social rehabilitation.

Other respondents believe that the definition of rehabilitation is not as important as the principles underpinning it and the ability to deliver a range of rehabilitative structures.

Conclusion

The Mid Term Review of the National Drugs Strategy notes the '*lack of understanding around what is meant by rehabilitation*' and describes it as being seen as embracing a wide range of services, for example, from '*personal development, training, community re/integration, access to housing, and access to employment*'. Emphasis on rehabilitation can range from '*therapeutic approaches to social re-re/integration*'.

This verdict is echoed in the research findings. It is clear that a vast majority of respondents see drug rehabilitation as being broader than problem drug use and addiction. For most, it is about dealing with the reality of clients' lives and their circumstances of disadvantage, marginalisation and disempowerment.

The research findings echo the belief that addiction does not exist in isolation, but rather that it is the product of the interaction of our natural and built physical environments, socio-economic status, and psycho-social conditions.

All rehabilitative and re/integrative efforts must recognise that.

Re/integration

As outlined previously, many of the respondents had difficulties with the use of terms such as reintegration in the survey. Respondents described how many clients feel they were never integrated within society in the first place, and that their participation on Community Employment represents their first attempt at integrating.

Most clients want to do more than just return to their pre drug-using situation and so, for them, re/integration is about going on to achieve more than they had before.

Other respondents believe that concepts such as re/integration are loaded with class bias, using middle-class values to determine what is “normal” and desirable.

Re/integration is seen as multi-faceted and highly contingent on each person’s circumstances, perceptions and needs. Respondents believe that re/integration is about overcoming isolation and developing a sense of belonging beyond the drug subculture.

It starts with the clients achieving a ‘*sense of ease*’, of belonging, of accessing ‘*the self knowledge to accept themselves*’.

Re/integration centres on the family, be that family of origin, or with their child/ren. This is not to say that returning to the family of origin is always the best option for clients, but that re/addressing the relationship is essential.

Some respondents believe that re/integration (and by extension rehabilitation) must deal with community issues. For others, it was about being able to access mainstream supports and services, about feeling part of everyday society, being able to ‘*take part in every day activities*’, ‘*what other people think of as normal*’.

Re/integration was also described in terms of '*being back on the road towards education and training*' and of being able to play a '*productive role in society*'.

In short, re/integration primarily represents social re/integration not re/integration into the open labour market. Where labour market re/integration was cited it was seen as a later stage, and as just one means of achieving overall re/integration within society. This conflicts with later survey findings that show that the majority of respondents see participation in the labour market as an indicator of progress.

Can this be measured?

Re/integration is seen as contingent on the extent of drug use and the extent of damage caused by drug use. Furthermore, respondents see it as being highly relative - dependent on individual needs and criteria, and difficult to uniformly define. Re/integration is described as taking place on an individual basis through small steps. Most suggest that progress in re/integration is best achieved through care planning, where re/integration needs are agreed with clients and thereafter worked towards. Others believe that re/integration is '*fostered not measured*'.

For most, re/integration is about finding '*a personal fit*': about each individual client being able to forge a productive role in society that reflects *their* aspirations.

Re/integration and Special CE

Clients believe that participation on Special CE provides a chance to change - and to change publicly within their own community. They describe it as a means of reclaiming or re-determining identity within the community, and of negotiating re/integration. For example, clients describe being able to walk into a shop with their '*heads held high, not being followed*' as re/integration and indeed measurable progression.

These sentiments are echoed throughout the survey findings, with respondents citing further examples of how Special CE fosters re/integration at family and community level. Respondents spoke of how being on CE provided sufficient stability for individual clients to be able to return to the family home or to have access to their children, factors that were central to the client's re/integration.

Respondents were therefore clear that Special CE programmes must not become ghettoised, but must integrate into the community. There was strong support for services and facilities to be made available to the wider community. This was seen as crucial in helping to build links and overcome or avoid stigmatisation between clients and the wider community. Where premises allow, a number of Special CE programmes in Dublin do this, opening the facilities to older people for social activities for example, or providing alternative therapies to the wider community as well as the client group.

Many respondents were critical of Special CE programmes as a whole, criticising the failure of its loose structures to challenge behaviours, and accusing it of creating an unrealistic expectation of what the real world of further education or work will offer. The income levels available to CE participants were also criticised as creating what was described as a '*false re/integration*' that may not be matched once the client progresses.

Conclusion

The European Monitoring Centre for Drugs and Drug Addiction defines the term social integration as '*any social intervention aiming at integrating former or current problem drug users into the community*'. They further break down social integration into the three pillars of housing, education, employment and vocational training, seeing treatment as a linked, but separate, intervention.

As a society we have norms, common values and sets of acceptable behaviour for how we make requests, express anger, and seek to resolve differences. Re/integration is in part about the ability to work within that construct or to be able to challenge it constructively. Merchant's Quay have shown that the development of core social skills is central to re/integration programmes (Lawless and Cox, 1999).

Re/integration should be seen in the overall context of an individual care plan and case management approach, which emphasises a process of development unique to that individual client in the context of an integrated programme of continuum of care. Any re/integration programme should focus on self, family, community, mainstream services, and wider society including the labour market.

It is also clear from the research findings that there is a strong expectation that re/integration is about challenging, supporting and changing behaviour and providing clients with the skills to operate effectively within wider society.

Progression

The survey findings demonstrated a clear understanding of the slow, incremental nature of progression in a rehabilitative context. There was also strong support for progression to be conceptualised in terms other than progression to the open labour market. Just as re/integration was seen primarily in terms of social re/integration, progression was perceived as personal progression rather than progress to employment.

Relapse is part and parcel of many people's recovery. Respondents describe how relapse - by its very nature - makes it difficult for clients in recovery to follow a linear progression line. Progression was described as being '*all about the next step whatever that step may be*'; that is to say, in developmental terms. The danger of setting a client up for failure was cited; when a client progresses too quickly only to then relapse.

There was a strong sense of frustration that there are few suitable progression routes available to Special CE clients. The length of the existing programme was cited as the main reason for this. Many respondents strongly believe that three years is simply not long enough to deal with the range of issues clients present with **and** to support them in becoming work-ready.

Still, there was also widespread unease at the progression rates within Special CE programmes, and a perception that insufficient emphasis is placed on progressing from the projects. Many respondents believe that Special CE has acted as '*a holding area*' only and that once '*people's time is up, that's it, they're back to square one. No moving on, no nothing*'.

Progression issues

The vast majority of respondents believe that progression to the labour market is too narrow a focus and is an unrealistic indicator of progression for the client group accessing Special CE. However, for a minority of respondents, Community Employment - by its very nature - must focus on labour market progression. For these respondents, this means that clients should **not** be accepted onto Special CE programmes unless they are able to progress within the programme timeframe.

The majority of respondents agreed that progression must be flexible. Nevertheless, it was also believed that progression must be visible and that Special CE cannot simply be a '*diversionary tool*', i.e. a mechanism for occupying people.

The lack of structure within individual Special CE programmes was cited as a major barrier to progression of any kind. Respondents spoke of the projects working in chaos, '*running to stand still*', and failing to address clients' basic adult education needs - an objective that must be met if clients are to progress to other education or training options.

There was also concern that maintenance on methadone and giving clean urine samples has become the sole focus in measuring progression. For many respondents, while clean urine samples or the reduction of methadone are recognised as important to recovery, they are not seen as the totality of progression.

This feedback pointed to the tension between the expressed and clear wish of clients for increased *optional* urine testing and practitioners' concern that this is an external control and not a replacement for effective relapse prevention and coping skills. The point was made that a client can be "clean", but simultaneously making little progress in any other area. The focus should be '*on dependency not the drug*'.

Progression to employment

As outlined previously, the survey findings indicate that progression to the labour market is too narrow a focus, and an unrealistic indicator of progression for the client group accessing Special CE.

Many clients cannot access the labour market as they have criminal convictions and are unable to gain the Garda Clearance Certificate required by many employers, particularly in the public sector. Respondents spoke of clients in a legal limbo: ready to work, but unable to secure employment.

Some clients may indeed be unable to progress to the open labour market and may need sheltered or supported employment or occupational activities for the foreseeable future. Communities were called on to create social economy programmes as a means of securing meaningful activities for clients who were not seen as having the capacity to progress.

Measurement issues raised

Some respondents believe that levels of methadone dosage could be used as a progress indicator, with reduction to 40 milligrams cited as a successful progress indicator.

Other respondents strongly dispute this assertion, describing how medication levels are too personalised, with some clients incapacitated by 20 milligrams and others functioning on dosage levels as high as 100 and 120 milligrams. The issue of poly-drug use and lack of compliance with urine sampling would render this a meaningless progress indicator.

Respondents maintain that progression indicators, particularly with client care plans, must challenge dependency and previous patterns of behaviour. For example, by the second phase of a Special CE programme, respondents believe that the *'ability to turn up on time should be seen as normal not something that attracts praise'*.

There was strong support for progress indicators to be time-limited and attached to overall stages of development. These findings also highlight the need for common standards of assessment, progress reporting and referrals, with standardised staff training across the Task Force as a whole.

Conclusion

It is clear that the issue of progression must be dealt with. It is the cause of much tension between Special CE programmes and their funders, and within the community of interest.

A re-adjustment of progress indicators to reflect the slow, incremental, developmental focus of the work of the projects is needed. These indicators need to be recognised and accepted by all agencies to allow more co-operation.

Projects themselves also need to put structures in place to make progression to the open labour market more of a reality for the client group.

Achieving stability

The survey explored understandings of what it means, in practice, to have a stable living environment. This was considered important for the purposes of agreeing common indicators for assessment, progression and referral.

Similar to the findings on re/integration and progression, the focus of the majority of responses was on very individual, practical applications.

Some respondents believed it meant to be drug free, meaning - for the most part - on methadone. However, the majority of respondents see having a stable lifestyle as much broader than treatment, encompassing a range of psychosocial elements.

Of primary importance to respondents was a client's ability to look after themselves, their health, and their children. There was also a strong recognition that stability means *'taking care of business'*: dealing with any additional outstanding issues such as housing, health, or justice, in a timely and constructive manner. There was also agreement that stability means *'doing the small things'*, *'eating properly'*, *'collecting the children from school'*, and *'paying bills'*.

Being stable means having a *'purpose to life'*, *'being a productive member of society'* and *'having a place in society'*. For many this means being in education or employment, for others it means to be positively occupied or able to access mainstream services.

There was also a strong sense that being stable means breaking away from old patterns and forming new ways of managing. That could mean not being involved in illegal activities, finding alternative ways to relax and enjoy oneself, or going on to create "an-ex role" - to have completely broken from the problematic drug using past.

Many of the responses focused on the client's ability to have and sustain significant relationships, whether this pertains to intimate relationships, relationships with child/ren, the wider family or all of these. For some it meant to re/build positive relationships with service providers and so have access to a range of support structures. A spiritual dimension to this process was cited in some cases, while for others it simply meant being involved in the community or sport.

The majority of respondents maintain that being independent and overcoming dependency is key to stability.

Drug free living

The lack of clarity about the term “drug free” was raised in the initial consultations and client focus groups. In the follow up survey, we attempted to explore this further, and to see if it is possible to reach agreement on what is meant by “drug free” living.

A wide range of opinions on the concept of being “drug free” were evident. Many respondents believe it is easy to define “drug free” in theoretical terms, but that it becomes problematic when placed in the context of the reality of clients lives and what they can achieve. The point was also made that in defining “drug free” we must be aware of the lack of an alternative treatment infrastructure to methadone maintenance.

According to the research findings, there is no shared understanding on this issue of definitions, with responses falling into the three broad definitions outlined in the questionnaire. “Drug free” can therefore mean:

- Abstaining from mood-altering mind-changing chemicals, or
- Not being compromised or controlled by drugs or alcohol, or
- Being free of “street” drugs and their associated lifestyle.

The research findings show a very ***slight*** majority supporting the definition of “drug free” as being ‘*not compromised or controlled by drug use*’ with the next biggest grouping seeing “drug free” as ‘*being free of “street” drugs and their associated lifestyle*’. Notably, there was a much lower level of support for an abstinence definition.

Other respondents define “drug free” living as using legally acquired, prescription drugs only, including methadone. Others again define “drug free” living as stopping self-medication: not using drugs - prescription or otherwise - as a crutch. A small number of respondents defined “drug free” living as going beyond abstinence to dealing with the emotional issues and circumstances that lead to the problematic drug use in the first place.

Problems defining “drug free” living

Any attempt to define what is meant by “drug free” living needs to be put in the context of how damaging a problem drug use was for the individual client. If methadone has helped bring stability into people’s lives, and is even perceived as having saved their lives, this should be reflected in any understanding of what “drug free” living means for that client.

Many respondents feel that definitions of “drug free” living must consider the context of drug use in Ireland as a whole, taking into account prevalent attitudes to alcohol and mood-altering substances, particularly prescription drugs. These respondents believe that injecting opiate users should be assessed by the same standards as the whole population when it comes to defining “drug free” living.

Respondents also had difficulty with the dominant focus on illegal drugs. They compared the problematic drug use of a joint at night to a glass of wine, whereby one is illegal and socially unacceptable and the other is legal and normalised. Both, they argued, can nevertheless have damaging effects.

Many respondents view rehabilitation in terms of being stabilised on methadone. Others, particularly those with personal experience of addiction, made a clear distinction between being “dry and sober” or “clean but crazy”, meaning that being free from opiates is just one part of the equation.

For these respondents, rehabilitation is about dealing with what Tony Keogh, of the After Care Recovery Group, called OBOW: the Outstanding Body of Work. From this viewpoint, methadone is seen as preventing people from dealing with their outstanding emotional issues and keeping them in a “drug user” role.

How understandings of what it is to be “drug free” impact on Special CE programmes

The majority of respondents see merit in the use of methadone as a stabilising factor in people’s lives, but are very critical of how it is administered.

There is fervent and widespread criticism of the lack of control clients have over their treatment. Survey findings on this are explored in more detail in the chapter *Emerging Issues*.

Some concerns were also raised regarding the motivation of clients who attend treatment purely because of the threat of custody or as a bail condition.

There was widespread concern about the problematic use of prescription drugs and what respondents see as their over-prescription.

Respondents described how it would appear not to matter when high levels of benzodiazepines show up in urine samples. Nevertheless, clients are very often unable to participate fully on the programme due to excessive intake of these drugs.

The survey also highlighted the interconnectedness of clients’ participation in methadone clinics and their participation in Special CE. It is a requirement of all Special CE programmes that clients must be on methadone treatment to participate. Some projects will accept clients only on referral from the treatment clinic, while others will also accept those referred by their own prescribing GP.

In the focus groups convened for this research, clients expressed particular dissatisfaction with having to attend a particular clinic, rather than retain their own GP.

The use of urine testing to monitor drug use was questioned. While many clients expressed a wish for urine testing to be facilitated at least twice a week, project staff expressed concern that this places too high a focus on external control mechanisms. Others, including clients, described the urine sample process as being flawed, explaining that it was easy to use opiates or other illicit drugs and still produce clean samples if the timing was well managed.

Other clients were unhappy that their ability to detox meant it was harder to stay on Special CE. Conflict arises where a client wishes to be drug free -meaning abstinence -and where the majority of clients are on levels of methadone that impair their capacity to engage.

There is also the irony that, by achieving abstinence, they may no longer meet the criteria for participation on Special CE. Clients spoke of their deep-seated frustration at having to stay in what they describe as a drug-using atmosphere when they wish to continue receiving the supports accrued from CE.

The absence of a programme or project for clients who wish to detox from **all** drugs was highlighted.

Conclusion

With the changing environment of problem drug use and increasing poly-drug use it is hard to assess when a problem drug user is “active”, “non active” or “in hibernation” if we rely solely on clinical assessments. This raises questions as to how Special CE programmes should respond.

It is important that we move away from what one respondent described as ‘*the emotional landmine of methadone*’, whereby methadone is seen as either being “good” or “bad” to a situation. Methadone must be viewed as one route to recovery, not the final solution.

The effective monitoring of problematic drug use should focus on the dependency, not the drug. Changes to the operation of Special CE are required to support that.

CHAPTER 2

SPECIAL CE: ROLES AND EXPECTATIONS

How Special CE is perceived

The findings demonstrate very mixed views on the role of the current model of Special CE and its appropriateness as a mechanism for working with people requiring drug rehabilitation.

Most of the respondents were aware of Community Employment's role as a labour market intervention, but believed that the ethos of local drugs projects with specially designated CE places is one focussed on personal development and supports to drug rehabilitation - rather than progression to the open labour market.

Overall, respondents, including Special CE programmes themselves, were very negative about the role of Special CE programmes, believing that CE, as it currently operates, is a wholly unsuitable means of working with people in need of drug rehabilitation.

Many of the more negative responses, including those emanating from within CE programmes, were based on a sense of disappointment that Special CE has failed to develop as was expected since the places were first ring-fenced for drug-related projects.

Community representatives acknowledge the hard work and lobbying that took place to secure the specially designated places and the fact that Community Employment and FAS was there when they had nothing else.

The research findings clearly show that Special CE programmes have been and continue to be the central plank of rehabilitation services at local level. There is a huge range of excellent work carried out and they make a real contribution to clients' lives working, for the most part, in very limited circumstances.

In spite of this there is a strong sense that, as it is presently structured and operating, Special CE is mostly failing to meet the needs of clients and is not providing adequate drug rehabilitation or any long-term solutions. Instead, respondents argue, through its structural make-up, Special CE is trapping clients, and by extension the community, in a *cul de sac* of non-progression.

How effective is Special CE?

The survey results on the effectiveness of Special CE were very mixed and, at times, contradictory. Respondents believed that it is not effective at all, but that it has to remain in place. Equally, some respondents believed it is the only programme to truly meet clients' needs, yet maintained that it could not, in its present format, tackle clients' priority issues.

The majority of concerns raised centred on issues such as premises, facilities, staffing levels and qualifications, and a perceived lack of accountability within Special CE programmes, rather than on the role of FAS itself or the work of the projects. Many of the concerns relate to Community Employment as a whole and are not exclusive to Special CE. For example, criticisms of Special CE and how it interacts with social welfare payments pre-date the special designation and ring fencing of places and are inherent in the operation of Community Employment itself.

Many of the positive responses focus on how participation in Special CE has impacted on individual clients' lives and well being, describing how *'there are people walking around today that would be dead if it wasn't for CE'*, as one respondent put it, and highlight that CE is *'the only show in town'*, and as such there are few meaningful alternatives available to the client group.

These responses echo those of the clients, who described CE as providing the opportunity to develop self-confidence, pride and a sense of dignity and how participation in the project has led to real change in their lives.

Respondents with extensive personal dealings with individual projects and clients were more likely to be supportive of the programmes. Respondents with stronger professional backgrounds in addiction and drug rehabilitation tended to be more critical, seeing it in a less personalised context and locating their criticisms of Special CE in the context of failings within drug rehabilitation policy overall.

Where does the problem lie?

Respondents, including those respondents within the projects, who perceived Special CE as struggling to meet the demands of the client group, of *'staggering from crisis to crisis'* or as *'running an ambulance service'*, were more likely to want to see Special CE replaced with an alternative drug rehabilitation approach.

The lack of a comprehensive treatment and re/integration framework poses huge difficulties. As one respondent described it, Special CE is, for most problem drug users, *'all there is, without CE they have nothing'*. This places enormous pressure on projects *'to meet each and every need,'* and leads to unrealistic expectation of what Special CE is, or should be.

It is believed that current Community Employment structures and funding criteria hinder progression. As one respondent frankly put it: *'It pays projects to keep clients who should not be there'*. On the one hand, respondents believe that Special CE runs the risk of becoming *'a holding place'* for problem drug users, and equally, of holding back progression-ready clients *'as they are easier to deal with'*.

All respondents believe that the current model of Special CE as a whole is too loose, lacks the appropriate structures and staffing levels, and is too isolated from other rehabilitation routes. Respondents believe it is too insular looking, and that there is too much duplication between the work of the Special CE programmes, in terms of advocacy and support services, and other agencies.

Conversely, respondents equally believe that the range of work and interventions carried out by Special CE, day in and day out, is overlooked. Projects maintain that it is because there is no meaningful alternative or because the level of support required is beyond services that do not have ongoing and daily contact with the clients.

There is widespread agreement that Special CE, as it currently operates, is not meeting the educational needs of clients, with some clients leaving the programme after three years still struggling with basic literacy problems. It is agreed that Special CE should considerably increase its education function with more improvements in basic adult education, an individual focus on training and clear accreditation routes.

Respondents also believe that the success or otherwise of Special CE within Dublin North East is too dependent on the commitment and expertise of individual staff or sponsor members and that it needs to be placed in an interagency rehabilitation framework. There is strong support for the Drugs Task Force taking a greater role in coordinating aspects of the programme's work and leveraging the necessary funding to support changed work practices and programme structures.

The training allowance and its remuneration level was seen by the majority of respondents as essential to client's rehabilitation with only a minority of respondents expressing concerns that it would act as a false motivation.

Limitations of CE

There was a strong sense of frustration that there are few suitable progression routes available to Special CE clients. The length of the existing programme was cited as the main reason for this. Many respondents strongly believe that three years is simply too short a timeframe to deal with the range of issues clients present with **and** to support them in becoming work-ready.

Still, there was also widespread unease at the progression rates within current Special CE programmes, and a perception that insufficient emphasis is placed on progressing from the projects. Many respondents believe that Special CE has acted as '*a holding area*' only and that once '*people's time is up, that's it, they're back to square one. No moving on, No nothing*'.

The mismatch between Community Employment's stated aims and objectives - i.e. to act as a labour market intervention -and the reality of the rehabilitative work Special CE programmes are involved in, has led to what many respondents describe as an unrealistic expectation of what clients can achieve within the projects. For example, some respondents made a distinction between education and training - education being outside of FAS's area of responsibility. Yet for most respondents they are both tools to the same end.

There was a certain frustration, among some FAS personnel and others, that the original aims and objectives of Community Employment have been forgotten and that not enough credit is given for the adaptations already made to accommodate the work of the local drugs projects.

Future focus of Special CE

While, as outlined previously, the majority of respondents do not believe that the current Community Employment model is appropriate as a drug rehabilitation mechanism, respondents do, as a whole, believe that the work of Special CE programmes should continue with modifications and additional supports. When asked what the focus of Special CE should be, the vast majority of respondents stated that it should continue delivering a mix of services rooted in a strengthened therapeutic environment and dealing with the range of interconnected issues. Strong support for the provision of re/integration for clients is evident from the survey, with a particular emphasis on health, social services, housing and counselling. It is clear that the majority of respondents view Special CE, primarily, as a mechanism to support drug rehabilitation.

The majority of respondents believe that Special CE ***should*** have a therapeutic function as its primary role. Second to that was the role of advice and support. Only then were education and training considered important. Even the minority of respondents who believed that Special CE should focus solely on education and training saw therapeutic and advocacy functions as being central to its effective operation.

It is evident from the survey findings that the majority of respondents base their views on what work actually takes place within projects rather than FAS guidelines for Community Employment. Special CE is viewed as a support to drug rehabilitation and it is judged on its success or failure in meeting the needs of the client group, not on the original aims and objectives of Community Employment.

While many respondents see Special CE as having a recreational function, there are serious concerns about the use of purely diversionary activities. There was widespread concern that recreational activities are too frequently delivered in the absence of a care plan or without being embedded in a rehabilitative approach.

While respondents do believe that clients need social activities, it is also believed that these are best delivered outside CE programme hours.

Respondents see Special CE as playing a key role in showing that alternatives to a drug lifestyle are possible, and in facilitating independent living and providing opportunities for self-expression. The level of interaction involved in the work and activities of the projects means that Special CE is seen as providing the best means of building positive relationships with clients in order to make full progression possible.

It is recognised that these changes cannot happen in the current circumstances; that within the current premises, and with current facilities, staffing levels and qualifications within Special CE programmes, resources and structures are insufficient. Serious well-founded concerns were raised at the ratio of fully qualified staff to staff who are themselves CE participants and in training. This is explored further in the chapter *Staffing Issues*.

It is believed that a major policy change is required at national level to make the necessary changes possible, matched by an increased commitment to working to common standards at Task Force level.

From Special CE to a re/integration programme

As outlined earlier in this report, in terms of the best way forward, there is a clear distinction between those who believe that CE is wholly unsuitable for drug rehabilitation work and those who believe that, with further adaptation, Special CE can work effectively.

For those respondents who believe Special CE programmes can be supported to work more effectively, it is agreed that this will only happen if the work of the projects is restructured and placed within an interagency framework. Many respondents see this as the best way to channel the experience and expertise built up within the community to meet clients' multiple needs.

Many believe that better policy and practice on assessment, progression indicators and referral, together with the development of pre-CE programmes, would address many of the issues within Special CE.

Indeed, two of the Special CE programmes have had or do have "lead-in" or pre-CE programmes in place to allow for better assessment, supported orientation and preparation for the realities of the Special CE programme. They report mixed levels of success with this approach and state that it is not a replacement for an interagency model that addresses the full range of client needs.

There is also a sense that, while rehabilitation and re/integration drugs projects need to be community-based, they cannot be wholly dependent on community structures, but also need outside inputs.

In this regard, any model of Special CE needs to be one part of a wider framework for rehabilitation and re/integration, based on a continuum of care model jointly run with community and professional expertise.

Focusing on the future not the past

It is recognised that the designated places on CE were originally identified as the mechanism to develop work experience and training for former addicts who were job-ready and as part of an integrated support service (Bruce, 2004:32). By and large, this is not the client group with which Special CE programmes now work.

However, Special CE programmes across Dublin have been and continue to be the central plank of rehabilitation services available at local level (Citywide, 2004). The broad range of services provided needs to be formally acknowledged and funded by all agencies concerned with problem drug use.

The crux of the issue is not whether Special CE is or is not the appropriate mechanism for drug rehabilitation - it is agreed that it is not - but how best to meet the rehabilitative, educational and work-orientation needs of the clients.

It is more important to recognise and facilitate the clients that do present than lament the fact that they are not “stable” enough for the current structure of CE, more important to recognise the level of advocacy and support needed to work with clients in drug rehabilitation than decry the fact that other services exist to do this work. Rather than focus on what was *meant* to have happened within Special CE, energy would be better spent on considering how present structures and funding can be effectively pooled to make best practice happen.

Furthermore, it is clear that neat distinctions between active and non-active drug users do not reflect the reality of the client group. Relapse is part and parcel of recovery and few problem drug users make a tidy, linear transition from chaotic to stable to drug free.

As these realities demonstrate, crisis intervention is, rightly or wrongly, a major part of the work within the projects, yet the staffing levels and structures are not in place to support it. This impedes the development of core work, such as literacy and educational development.

Recognising realities

The fact is that Special CE is established. High levels of demand remain for Special CE places and few alternatives exist. The 2004 Bruce Review confirms that, for many participants, Community Employment is a key element in stabilising their daily activities.

Huge levels of learning have taken place and the structures are in place at local level. Any new programme put in place will have to include all the key elements contained within Special CE and address the shortfalls and limitations highlighted in this and other research. As such, Special CE is well-positioned to be redeveloped into a more cohesive rehabilitation and re/integration programme.

The problem does not lie in the aims and objectives of Community Employment. Programme priorities can be changed, aims and objectives can be redrafted, and new approaches supported. The challenge is to locate the best practice Special CE has developed and put in it an interagency rehabilitation and re/integration framework.

However, this cannot be achieved in isolation. It must be placed in an interagency framework within a continuum of care model. It requires commonly agreed standards of best practice together with interagency protocols. It also requires the funding and political will to make it happen.

Key weaknesses within the current operation of Special CE *can* be addressed. It is essential that the steep learning curve that projects describe is channelled into best practice, ensuring that no new project needs to go back to square one.

If this re-energising and reform of Special CE is to operate successfully, it needs extensive community involvement. There is widespread fear and suspicion that the work currently being done by Special CE will be dismantled before anything is put into place to provide clients with the support and interventions they require.

Expanding Special CE programmes

There is a clear demand for additional Special CE places, in spite of community and staff reservations regarding its operation. Those respondents who are active outside the catchment area of existing CE programmes maintain that there is unmet demand in their communities for the establishment of rehabilitative programmes.

This is particularly true of Howth, Bonnybrook, Artane and Coolock, areas with existing drugs projects that can clearly see the demand for an increased range of comprehensive programmes of support and intervention.

Expanding Special CE programmes in new Task Force areas could present an opportunity to develop a more comprehensive interagency rehabilitation and re/integration programme. It could act as a demonstration model of what the Special CE model **can** achieve when all the necessary supports and structures are in place.

Any new Special CE programmes or re/integration programmes developed must gain from the experience of the existing projects. They must be developed in an interagency context addressing the limitations of the current programme and building on its best practice.

Projects seeking to secure Special CE places will need to be supported through the development of best practice guidelines. In particular, guidelines for staffing ratios and qualifications, counselling roles and minimum standards for premises will need to be in place at Task Force level.

CHAPTER 3

INTERAGENCY WORKING

The need for an interagency approach

All respondents cited the lack of interagency approaches as one of the main barriers to the full effectiveness of Special CE and indeed to any work with problem drug users.

While many of the respondents spoke of good personal relationships across organisations and cases of strong individual co-operation between agencies, there is a clear absence of systemic interagency work. This is, of course, not unique to Dublin North East, but also true of Special CE across Dublin (Bowden, 1997; Bruce, 2004) and indeed is cited as a key weakness of Irish social services (Keane, 2004).

Special CE is supposed to be delivered as part of an interagency focus on prevention, treatment, rehabilitation, training and education for the individuals concerned. It is clear that this has not happened. It is also clear that there is a lack of organisational will to make this happen, as drug issues have slipped down the political and public agendas (Citywide, 2004).

Day-to-day, within Special CE programmes, the absence of interagency co-operation creates difficulties. The research has shown how very often, as is the case with secondary social welfare benefits, the interaction of CE with other entitlements leads to a loss of income supports. The discretionary nature of the decisions and the lack of an interagency forum to raise the issues for individual clients, means that clients and key workers are stuck in a merry-go-round of agency interaction trying to positively resolve various issues.

The research illustrated how the same issues are presented time and time again, such as the reduction of secondary benefits, or conflicts about methadone management. This puts undue pressure on clients and consumes an unwarranted degree of time and energy from project staff, only to represent again with the same or a different client. Such wasteful repetition reflects the lack of cohesive policies at national level, which Bruce (2004:88) describes as a '*gap in overall management in the provision of coherent and interconnected services critical to an effective interagency response*'.

Priority areas for co-operation

Treatment

The research findings clearly identified drug treatment as the primary area where interagency work is required. While the feedback was highly critical of present practices, provoking strong feelings and demonstrating stark differences of opinion, it is clear that respondents are united in their desire for improved approaches to treatment co-operation.

With parallels to the highly critical feedback provided by clients, many of the key informants were scathing about what they see as the lack of transparency, consistency, and accountability in methadone management. What is perceived by many as the clear exclusion of clients from decision-making around treatment is believed to undermine all other efforts at drug rehabilitation.

Clinical staff are seen as being too focussed on medical models of treatment and too removed from the range of interconnected issues at play in addiction and recovery. They are described as having too many clients to deal with, lacking specific expertise in problem drug use and resistant to change. These research findings are, however, stymied by the fact that clinical staff were not among the key informants, so the research is open to criticism on the grounds of balance.

Nonetheless, it is clear that there is a strong sense of frustration in the overall research findings at how powerless clients feel about decisions taken in relation to their drug treatment.

Other respondents were equally critical of the approach of some Special CE and other community-based projects towards treatment, particularly detox. Some projects staff are perceived as not having sufficient professional expertise to advise on treatment, and are therefore described as being unrealistic in their encouragement of clients towards detox. This is seen as creating mixed messages for clients, creating false expectations, and ultimately setting them up for failure.

It is clear that the research findings are mixed. For each project that has a poor relationship with clinical staff, another reports positive working relationships and close co-operation. Even so, all respondents identified a structured *treatment team* approach to treatment as being central to drug rehabilitation.

There is clearly a wide variation in the level of co-operation and positive relationships between the four Special CE programmes and the clinic teams, and within clinics themselves. Two of the projects have established professional working relationships based on trust and mutual respect. In these projects there is far less dissatisfaction among clients concerning their treatment.

There is clear demand that a treatment team be established for each client, representing the prescribing doctor and other members of the clinical team, the client's core counsellor, a member of the Special CE programme and of any other key agency. The research findings on rehabilitation and re/integration support this assertion, as it is clear that there needs to be a wide range of expertise available when making treatment decisions. In projects where there is a treatment team approach -in Rialto Community Drug Team for example -there are high levels of satisfaction with its effectiveness.

Other issues raised in the research, in relation to interagency co-operation on treatment, were the need for more doctors willing to prescribe methadone, a need for projects to employ doctors directly, and the training of others, such as community nurses, to dispense methadone, in order to increase the time that clients can spend with medical staff managing their treatment.

There are also serious concerns about the appropriateness of project staff collecting urine samples and the blurring of lines between projects and clinics in this regard. While it is recognised that there is a demand from clients for the facility, it is believed it should only be available in a clinical setting.

The research findings demonstrate strong support for a review of clinic opening times to facilitate clients, particularly those in work or work placements. This is seen as a matter of urgency.

Respondents also cited the need for a GP coordinator to support the work of prescribing doctors.

Calls were made for a review of the effectiveness of methadone as a long-term treatment option and a review of the current practice of benzodiazepine prescription on methadone treatment, within a rehabilitative context.

The need for more community-based detox options and respite facilities was seen as crucial to the development of a comprehensive rehabilitation infrastructure.

These and other treatment issues are further explored in the chapter *Emerging Issues*.

Housing and accommodation

The number of homeless clients, or those at risk of becoming homeless, is high. All respondents made it clear that clients cannot be expected to participate fully on projects if they do not have access to secure, quality accommodation. Feedback on this issue is present in the chapters on *Emerging Needs* and in the chapter *Client Focus Groups*.

The issue of rent allowance and how it interacts with Community Employment payments is a priority for clients and project staff. Previous work by the HSE in co-ordinating the work of Community Welfare Officers in the area was well received and clearly demonstrates that improved co-operation is possible. There were also calls for increased co-operation between county council estate management teams and settlement officers with Special CE programmes.

Many of the respondents spoke of the huge amount of brokerage and advocacy work that goes on around housing and described their frustrations at how, even if this is successful in an individual case, it does not lead to a change in practice or overall improvement for clients generally.

There is a demonstrated need for transitional housing at Drugs Task Force area level and for respite services, though it is unclear who would take responsibility for managing them.

As housing is such a cross-cutting issue, and involves such a wide range of agencies, it is clear that increased co-operation needs to be facilitated through an interagency forum rather than solely by developing individual working relationships on an *ad hoc* basis.

Social services and education

The research clearly located addiction and drug rehabilitation within a setting of social disadvantage and disempowerment. Ancillary issues to treatment, such as housing, health, community issues, justice, and childcare, are all central to an individual's ability to engage with Special CE and to progress.

The research findings demonstrated the range of services and agencies that clients interact with and the huge amount of brokerage and advocacy that takes place within Special CE programmes.

There were calls for increased co-operation with social workers, community and public health nurses, and education providers.

Justice

Many of the clients are attempting to address outstanding issues in the justice system as part of their social re/integration.

There are calls for probation and welfare officers to be more involved in the care planning of clients within Special CE, as well as support for increased co-operation, across Dublin North East as a whole, with the prison service. This is seen as essential to early intervention and outreach amongst the client group. More co-operation with FLAC, the Free Legal Advice Centres, is also required.

The role of the Garda Síochána was highlighted, particularly because their approach and levels of co-operation can vary from station to station and amongst individual Gardaí. The difference in the approach and work of the JLO at community level and other branches of the force was highlighted.

There were calls for a clear justice policy to be developed to support the re/integration and rehabilitation of clients.

The research findings also convey strong support for a formal system of expunging the criminal records of problem drug users who can demonstrate that they have rehabilitated. This would help remove barriers to accessing employment. The present system of Garda clearance is limited in what it can achieve. It is understood that any system of expunging records will take account of child protection concerns and should not apply to all charges and convictions.

The Equality Authority, in their review of the discriminatory grounds covered by the Employment Equality Act, 1998, call for criminal conviction grounds to be included in the legislation, based *'on the premise that discrimination against people on the grounds of their criminal record should only be permitted where the offence would be objectively incompatible with the requirements of the job'* (Equality Authority, 2002:8).

Current issues in interagency work

The research clearly demonstrates that more needs to be done to foster positive working relationships at organisational level.

There are fears that were the HSE to take responsibility for the projects, it would reinforce the continuing dominance of medical models at the expense of social models of practice within drug rehabilitation.

Lack of clarity within the HSE about the roles and functions of each area of work was criticised as adding to the lack of interagency co-operation for clients. In particular, the absence of meaningful operational budgets for the Rehabilitation and Integration Service means that their work, while highly valued, is not seen as driving the rehabilitation and re/integration framework.

The City of Dublin Youth Services Board (CDYSB) was also criticised for its lack of clarity in relation to the work of the Special CE programmes.

Equally, community organisations and projects themselves were criticised for failing to work co-operatively with other agencies. Territorial concerns and intra-project rivalries are perceived as diverting energy from projects and hampering the progress of clients.

The traditional make-up of Community Employment Sponsor Management Committees is seen as requiring more support. While strong on community issues and containing high levels of experience and local expertise, it is believed that these committees need more support to better meet the challenge of the changing face of problem drug use.

Many respondents perceive them as lacking the full range of professional expertise required, meaning that project staff are taking full responsibility for driving the programme or that staff and management are in ongoing conflict about key issues. There are calls for advisory teams to be put in place to support management committees in directing the work of the Special CE programmes.

There are also calls for what one respondent describes as '*honest conversations*' between projects, funders and service providers about roles and responsibilities, leading to increased transparency and accountability.

While the research clearly demonstrates good practice within Special CE programmes in optimising the use of available funding for programme delivery, it is felt that funders need to be more aware of and to take more responsibility for the effectiveness of the work.

Role of the Drugs Task Force

Many respondents were also critical of the role of the Dublin North East Drugs Task Force and what is perceived as a lack of strategic planning at Task Force level.

There were calls for the Drugs Task Force to take a greater role in co-ordinating certain elements of the programmes' work, such as facilitating an annualised staff training programme, developing interagency protocols and policies and securing funding for core supports.

There is strong support for a more effective mechanism of community representation and for service users to be represented on the Board.

Making interagency work happen

Special CE clients need to negotiate and manage relationships with multiple agencies, often with different functions, roles and interests, as part of their recovery from addiction. This is also due to their marginalised circumstances, resulting from poverty and disadvantage.

It is clear that an interagency forum is needed to case manage issues and priorities based on a client's individual care plan. It is also evident that structures and policies need to be put in place to clarify exactly where individual agency roles and responsibilities lie and to determine which agency is the lead agency for which issue. The role of brokerage within this system needs to be clarified and agreed.

However, the different administrative boundaries of the various agencies and organisations require a focused interagency initiative to bring all the key stakeholders together.

There are various models of good practice available on interagency protocols, most notably the Blanchardstown EQUAL Initiative.

The SAOL project, together with other key projects in the North East Inner City, is running a demonstration model, Progression Routes Networks, to ascertain the impact of key agencies working together to support the progression of a group of individual clients. Respondents believe that the outcomes and any successes of this work should be incorporated into the evolution of Special CE.

Respondents also believe that greater community awareness around how agencies work is needed in order for interagency co-operation to work well.

It is believed that the establishment of working relationships is as important as the development of new work practices.

Who should lead rehabilitation and re/integration programmes?

A majority of respondents believe drug rehabilitation projects should, in theory, be the responsibility of the HSE, and that FAS is not equipped to be the lead agency.

Many believe that '*community groups are out of their depth*' in what they are attempting to achieve with Special CE. There are huge levels of concern that the present situation is failing clients, putting them and staff at risk, and, in the words of one respondent, '*causing more problems than it solves*'.

Conversely, respondents were equally, if not more, critical of the role of the HSE. The HSE is perceived as having abdicated responsibility, failing to develop cohesive programmes and policies, and being reluctant to commit the level of resources and commitment that FAS has invested in the projects.

The majority of respondents, including HSE personnel, cite the lack of intra-agency co-operation within the HSE as one of the main barriers to cohesive policies on drug rehabilitation. The HSE is seen as '*too unwieldy*' an organisation to become the lead agency.

The Department of Community, Rural and Gaeltacht Affairs was also named as a possible lead agency, as was the Drugs Task Force.

The majority of respondents believe that Special CE should not be the responsibility of any one agency, with some respondents suggesting it be lead by an interagency team directed by a National Rehabilitation Agency.

Conclusion

It is clear that no one agency has the expertise or structures to deliver effective and sustainable rehabilitation and re/integration programmes in isolation. No single model of recovery and re/integration can suit all individuals.

Specific burdens regarding childcare, allowances, housing, health and imprisonment complicate personal goal-setting. Many Special CE clients are exceptionally marginalised and disempowered, with profound feelings of worthlessness and exclusion. Personal care plans are needed for individuals to advance. However, they cannot be delivered on in isolation within Special CE programmes, without the holistic, all-encompassing potential of an interagency approach.

Some of the issues need to be addressed at national level; for example, the administration of payment to Special CE clients, and the need for increased involvement and direction by the Local Drugs Task Force.

The substantial investment that FAS commits to Special CE is not being fully utilised due to a lack of interagency co-operation. The research demonstrates that, while the HSE does fund and actively support individual projects, this needs to be set in an interagency framework.

As previously stated in this chapter, there are good models of interagency work to draw from. The Northern Area Rehabilitation and Integration Service **has** hands-on experience in leading the development of common protocols by agencies working with drug users and former drug users. It was the lead agency on the Blanchardstown Equal Initiative, which is recognised as providing a model of good practice for timely and effective interagency co-operation.

Dublin North East needs to build on good practice already established to make interagency working a reality.

CHAPTER 4

FROM SHARED UNDERSTANDINGS TO PRACTICE

Protocols and procedures

As outlined in the earlier chapter, *Developing a shared understanding*, there is a clear need for the development of interagency protocols at Drugs Task Force level.

The research findings show strong demand for protocols around assessment, progress indicators, and referrals. However there was little data available to evaluate current practice and policies among Special CE programmes, although feedback was provided on the issues involved. There is evidence that it is an area that projects and agencies are becoming more focused on with the Rehabilitation and Treatment team, among others, developing clear internal guidelines for the work.

The research findings produced a wide range of data on the concepts of rehabilitation, re/integration, progression, and stability. At their core was a shared aspiration for clients' recovery and re/integration. They also illustrate the need for a commonly agreed assessment and referral criteria. It is evident that any discussion of progression is meaningless unless we are aware of the clients' ***starting point***, as well as their final goal.

This shared understanding can act as the starting point for the development of commonly agreed protocols and procedures. The feedback and agreed criteria to date is provided in full in the appendices. While not definitive, it is expected to form the basis of commonly agreed standards of assessments as part of a system of interagency protocols.

There was also strong support for confidentiality protocols within Special CE programmes, and between the projects and other agencies. There is clear evidence from clients and project staff that failure to maintain confidentiality protocols is a key challenge, and a major drawback, of working in a peer setting at local level. It is clear that additional staff training and organisational cultural change is required. The research findings on this are explored further in the chapter *Staffing Issues*.

The research illustrates the urgent need for interagency protocols to be put in place and highlights the concern that their absence should not be used as an excuse not to progress interagency co-operation.

Such co-operation requires interagency protocols on key issues of assessment, progression, referral and confidentiality, as outlined previously. It also requires agreed common standards for staffing levels and qualifications, programme components, counselling services, premises and other essential factors in the effectiveness of Special CE.

Assessments

The research findings demonstrate the need for a clearer understanding of the Special CE client group starting point. Conversations around progression will reach an impasse unless we know where the person is progressing **from**, as well as their final goal.

There was widespread agreement on the range of issues that need to be addressed as part of a client's re/integration, and as to what factors constitute a "stable lifestyle".

From this a list of key factors that assessment criteria need to take into account was compiled. This is incorporated in the appendices. While not definitive, it is expected to form the basis of commonly agreed standards of assessments, as part of an overall system of interagency protocols.

Measuring progression

There was widespread support for the progress indicators included in the formal consultation process. These had been drawn up based on feedback from the initial consultations and client focus groups.

The indicators range from social skills, such as interpersonal skills and the ability to take part in educational activities, to indicators of improved work routine and increased education. There are also indicators of harm minimisation and relapse prevention strategies, as well as improved external and significant relationships. Work and further education orientation were considered a major component of progression indicators, though it was stressed that these are considered part of the final stages of Special CE.

Consistent and widespread support was expressed for the inclusion of “quality of life” indicators in any progression indicators agreed. These range from accommodation and health needs to managing debt and poor credit history, and resolving community issues. A full list of the feedback is included in the appendices.

There were concerns as to how concepts such as pride and self-esteem can be measured. This highlighted the need for increased training and common standards in completing assessments, progression reports and referrals within projects in the Dublin North East Drugs Task Force area.

Progression, just as with re/integration, was seen as being best facilitated within the criteria of a client's own care plan, and as a reflection of a client's particular needs —not the needs of projects or funders. Respondents believe progression should be measured:

- At client's own pace
- By small steps
- By changing needs
- By multiple objectives
- By milestones individual to client

Referrals

As a society we have norms, common values and sets of acceptable behaviour for how we make requests, express anger and seek to resolve differences. Re/integration is, in part, about the ability to work within that construct or to be able to challenge it constructively.

Respondents cited the lack of commonly agreed assessments and progress indicators as leading to unclear standards in interagency referrals and leading ultimately to difficulties for clients in progression.

This is true of both referrals *to* and *from* Special CE programmes. In regard to referrals *to* Special CE, there is a clear need for an agreed number of referral points to be developed. This is needed in order to facilitate clients in accessing Special CE from a number of starting points, including, for example, GPs, counsellors, the Rehabilitation and Integration Service and other community groups.

However, referral to Special CE needs to be linked to a clear assessment process. It must be restricted to an agreed number and range of referral points, underpinned by policies and procedures to support Special CE programmes in dealing with any additional workload this may create.

Suggested points of referral include GPs, counsellors, the Treatment and Integration Service, youth workers, and community groups. An option for self-referral also needs to be built into the referral and assessment process.

Key factors that impact upon interagency referrals were developed for the research findings. Existing best practice outside of Dublin North East was also utilised. This is listed in the appendices. With further consultation, it is expected to form the basis of commonly agreed standards of referrals.

CHAPTER 5

STAFFING ISSUES

The initial findings produced a wide range of responses on the staffing arrangements within Special CE programmes, highlighting serious concerns about present staffing ratios and what is perceived as an over-reliance on CE support workers for what is highly skilled and challenging work.

From consultations with clients and staff alike, it was clear that the nature of the multi-faceted roles and responsibilities within the Special CE programmes places a heavy responsibility on staff, and that some Special CE programmes are better positioned to respond than others.

There are also concerns about the working conditions of CE support workers, the lack of a cohesive approach to training, poor pay in relation to the challenging roles and responsibilities involved, and weak progression rates.

It is evident that the Community Employment staffing structure, even with the 25 per cent support worker ratio for Special CE, was not designed for the level of rehabilitative work that is now taking place. Projects have responded well to the challenge, however, and most have secured separate funding for additional fully qualified staff. Specialist training has been funded through the Drugs Task Force, and those staff without specialist training and qualifications have clearly worked hard to up-skill.

Still, it is clear that there is a pressing need for more cohesive staffing policies and for an annual training plan for all staff, particularly CE support workers.

Limits of current staffing structures

The research findings demonstrate that work on Special CE programmes is highly skilled, personally demanding, and intensive. It requires a mixture of personal aptitude, practical experience, proven core competencies and formal qualifications to work effectively and safely with clients.

It is clear that the success of the projects to date has depended on the skill and drive of supervisors and project managers, rather than the structure of Special CE itself. Co-ordinators, supervisors and support workers, who are themselves Community Employment participants, have worked hard to gain the necessary professional qualifications to match their hands-on experience.

Staffing arrangements vary considerably from one Special CE programme to another, with some projects having well-balanced ratios of staff to clients, and adequate proportions of highly qualified, experienced staff in relation to those staff in training. Supervisors have invested considerable time and energy in developing their own skills, and those of their staff, and are well aware of the issues involved. Nevertheless, all were agreed that the existing system in those projects - with a heavy reliance on CE support staff - is unfair, on both the clients and support workers involved.

It is a particular source of frustration to more experienced CE Support Workers that it has proven so difficult for them to progress to similar work in the open labour market. There is recognition that training levels have improved. However, there remains criticism that CE Support Workers are not provided with sufficient accredited training in a structured format. CE Support Workers would like to know that when they finish their time on CE they will leave with a portfolio of training and qualifications.

The research findings illustrate a certain amount of defensiveness around the issue of qualifications. Support workers quite rightly point out that qualifications are nothing without hands-on experience. Still, it is clear that the work involved, particularly that of key workers, demands formal training, qualifications *and* practical work experience.

Concerns for staff and client well being

The research findings highlight grave concerns about the appropriateness of unqualified staff providing treatment advice, making crisis interventions, providing basic counselling functions and being responsible for client care planning. There were also concerns raised about non-clinical staff involvement in the collection of urine samples.

While a valid criticism of the Special CE programmes is that they can be too crisis driven, the fact remains that local projects are where the crisis situation will be brought and it is there that adequate responses need to be available. More specialised training needs to take place and much more information and direction is required on appropriate referrals

There is evidence of poor adherence to confidentiality protocols within some of the Special CE programmes. Clients and project staff believe that failure to maintain confidentiality is a key challenge for clients and staff. This is an organisation-wide problem within the projects concerned. It is clear that additional staff training and organisational cultural change is required.

There is also evidence that staff-client boundaries are not always clear, with staff expressing unease about levels of disclosure and what they see as inappropriate disclosure off-site. Clients also reported what they saw as inappropriate interventions by staff outside of the Special CE programme. The fact that working locally means staff and clients often socialise in the same places was seen as presenting difficulties.

Concerns that some staff have difficulties in establishing clear professional boundaries with clients, illustrated by the evidence of inappropriate interventions and contact outside of the structure of the Special CE programmes, reflected staff uncertainty as to the limitation of their roles and capacities.

Other respondents describe a lack of clarity as to what constitutes advocacy within projects, believing that the current approach fosters client dependency.

Demands were also made for more training and uniform, organisation-wide, policies to address these issues. However, it is clear that this is an ongoing development issue and that one-off training is not sufficient. It is suggested that such training becomes part of the induction process for staff and clients, and that it is incorporated into an annual, continuous in-service training programme.

The difficulty in securing an appropriate gender balance among staff was raised. A lack of a focus on sexuality in the programmes was cited, and is seen by respondents outside of Special CE as a reflection of insufficient staff awareness. Respondents spoke of how female clients, in particular, can so easily become involved in inappropriate or damaging intimate relationships and that no one seems to address this issue.

According to respondents, more staff training should be provided on sexual orientation.

There is also a need, they say, for clear guidelines, policies, and procedures for employing former clients within Special CE programmes.

Confusion exists in some projects as to the role of support and supervision. Some staff view this role as providing personal counselling time, rather than as a work-related resource. Others see it as an add-on rather than a core component of their work. There is a need for commonly agreed standards of best practice in relation to support and supervision. However, it is recognised that this is, in part, dependent on the provision of adequate funding.

Respondents expressed serious reservations about Health and Safety policies within Special CE programmes. There were grave concerns that they lack specialist knowledge and that projects are not equipped to deal with potential accidents, such as needle stick/sharp injuries, blood/body fluid born exposure, blood spill or overdose.

Priority issues identified

Staffing roles

The work of Special CE involves a range of one-to-one work, key working and interventions. The ratio of qualified staff to clients needs to be significantly increased to reflect this, and core funding put in place to ensure its implementation.

Indeed, the roles and responsibilities of all staff need clarification. Additionally, a common grade system, salary scale and set of job descriptions needs to be established to reflect the roles and responsibilities of all Special CE programme staff.

In particular, the role of key workers needs to be clarified with minimum training, qualifications, and practical experience levels defined and agreed for the role.

The ratio of qualified, experienced staff to trainee staff needs to be significantly increased in some projects, with a common target ratio agreed at Task Force level.

Particular concern was evident regarding the appropriateness of people with basic counselling skills taking on specialist counselling functions. While there are elements of counselling skills within the role of key workers, the specific counselling function should take place outside of the project, where confidentiality and professional follow-on can take place.

Evolving role of CE Support Workers

Some respondents see the position of CE support workers as the exploitation of staff who are carrying out professional roles on CE wages. There are calls for some kind of bonus system of additional payments to be put in place.

Frustration is also felt because the very structure of CE means that CE support workers leave the programme just at a time when they have developed high levels of professional competency.

Equally, CE support workers are frustrated at the lack of career progression when they have completed their Community Employment. Many reported having to retrain or to return to employment that does not utilise the skills and experience they have developed within Special CE. They believe that external work placement opportunities should also be in place for support workers in their final year.

Others believe that clients are being put at risk as support workers learn on the job, gaining experience through trial and error.

Notwithstanding these concerns, most respondents see room for the continued involvement of CE support workers within Special CE. The 25 per cent worker ratio is seen as a valuable resource to the local community and as a means of providing local opportunities for work placements and training. It is also seen as a possible progression pathway for those clients who may wish to work in the field.

The role of CE support workers needs a total overhaul. The position must move to one of a trainee or work placement position within the context of a high-level, annualised and accredited training plan.

Support worker roles and responsibilities must mirror a staggered increase in formal accredited training, skills and competency development. Matching this with increased payments or benefits should be considered.

In particular, staff should not be given key worker responsibility without a commonly agreed minimum standard of training, professional competency and practical work experience. The Addiction Studies Certificate is seen by many as too basic a minimum standard of qualification.

This will need further deliberation by the Special CE programmes and Task Force, to ensure an agreed minimum standard of qualifications for each grade or level of staff member within the programmes.

Secure annualised training budgets are required for this outcome, delivered through a central co-ordinating body operating to agreed minimum standards.

Conclusion

The work that the Special CE programmes do is highly skilled work with very specific and specialised competencies and skills required. The work can, by its very nature, become highly personalised, leading to high levels of burn out, disillusionment and exhaustion. Only appropriate, high-level training, support and supervision and lengthy work experience can provide staff with the skills needed to sustain such challenging work.

CHAPTER 6

SERVICES AND FACILITIES

On site facilities

Kitchen facilities are seen as crucial to the work of Special CE programmes. Every respondent agreed that kitchen facilities provide opportunities for increased nutrition, life skills and health management. The kitchen area must be large enough to cater for the entire group and it was recommended that at least one meal a day be provided. The kitchen needs to be kept separate from the classroom area.

There is also strong support for the provision of ***showers and washing machines*** as part of the Special CE infrastructure.

The provision of onsite **gym facilities** had strong support among clients, but other stakeholders believe that, as a resource, it would be too difficult to maintain and that instead, clients should be supported in accessing gym facilities in their own locality. Maintaining fitness, as part of an overall healthcare plan, is important to clients' well being. It is also recognised that some clients may find bodybuilding and other gym-based activities to be good methods of establishing routine, building self-esteem, and keeping occupied.

Mixed levels of support were expressed for the idea of dedicated **Information Technology facilities** within Special CE. Respondents from within the Special CE programmes were more likely to be in favour, while others - outside the Special CE programmes - were more likely to see it as a duplication of resources. However, it is recognised that IT can play a central role in many aspects of adult education and that it is preferable that Special CE programmes have easy and regular access to IT facilities in a location that suits them. Where the premises are multifunctional and have a range of community interests involved, it makes financial sense for the IT facilities to be onsite.

Core services

There were calls for **primary health care** to be provided within the treatment clinics. It is seen as essential that clients have ongoing and easy access to a full range of medical interventions related to their problem drug use.

Counselling is a key element of rehabilitation and re/integration programmes. All respondents cited the availability of counselling as a key part of Special CE. While it is accepted that counselling is not a panacea, and that some clients may not wish to avail of the service, it is essential that the option be there. It is important that clients have access to crisis intervention and non-appointment based counselling services, as well as individual, scheduled counselling.

As noted elsewhere in the report, it is crucial that counselling is provided by fully-qualified and experienced counsellors. A panel of counsellors needs to include counsellors with a range of specific skills training and expertise, particularly in the area of abuse, sexual assault, prostitution, sexual orientation and family intervention.

Clients want to see counselling delivered separately to the Special CE programme, either, on-site but out of hours and/or in a separate but adjoining location, or off site. They want counselling to be made available as part of the “move on” and after-care programmes. Clients want to see a consistency of counselling provision, so that they can establish relationships with counsellors. They would also like to see access to a range of counselling styles.

Community based services

Childcare provision is considered an essential, and it was seen as important that it should **not** be provided within the same location as the Special CE programmes.

Instead, respondents favoured a range of childcare solutions, from reserved places in local creches to paying the childcare costs for recognised child minders. Childcare is needed on Special CE for all child dependants - pre-school and school going. It is essential that the programmes make provision for childcare during school holidays and for school in-service training days.

Where the local creche **is** located in the same premises as the Special CE programme, it was seen as essential that the creche did not cater exclusively for the child/ren of clients, in order to promote community-wide participation.

There was strong support for the provision of **drop-in** facilities as part of any re/integration programme. However, it was seen as essential that they are kept physically separate from the Special CE programme and also maintain a separate ethos and structure. While it is expected that there would be strong levels of co-operation between the staff, it is important that clients do not see re/integration programmes as an extension of a drop-in service.

There was also support for the provision of **aftercare** as part of the “move on” element of re/integration programmes. This is commonly provided within the same structure as the core re/integration programme, but there was also support for it to be provided at another community location. It is essential that any aftercare service operate with flexible hours, so as to enable access by clients in the workforce or further education.

There was a strong demand from clients for **out of hours services**, particularly weekend provision, and for alternative **social activities** to be available. This is an area that needs more attention to see how it can best be delivered on, at either local or Task Force level.

There was also a clear demand from clients for **peer support**. For most of the clients, peer support outside of the Special CE programme has been NA. There are mixed experiences of NA within the research. Some clients find it works well as a source of peer support. However, the majority of clients who shared their view of NA for the research were highly negative about it. There may be some confusion about the actual aim of NA, which is not that people need to be free from addiction but that they are striving to be so.

However, the clients were looking for more structured peer group support, with more clarity about problem drug use. Female clients also had issues with what they saw as the predatory nature of NA meetings. There was support for more women-only avenues of peer support. Peer support is seen as an essential pillar of aftercare and it is important that opportunities for safe, structured peer support are developed.

Respite services and **community based detox facilities** were seen as crucial to the rehabilitation infrastructure of Dublin North East. More work is also required to see what steps need to be taken to have this in place.

There was strong support for services and facilities to be available to the **wider community**, so that Special CE programmes do not become ghettoised.

This was seen as crucial in helping to build links and overcome or avoid stigmatisation between clients and the wider community. As outlined earlier in the research, where premises allow, a number of Special CE programmes do or have done this, opening the facilities to older people for social activities for example, or providing alternative therapies to the wider community as well as the client group.

Respondents are clear that where projects are resource-restricted, existing clients must remain the priority. However, it is clear that opening up services, while challenging to administer, brings real benefits. It also allows **former clients** to continue to access supports and services such as alternative therapies or counselling. Former clients can have immediate and pressing needs for supports and services and appointment-based systems may not always work. Where walk-in services are not available to the wider community, clear referral systems to services on demand need to be established.

Premises

The quality and size of the premises where Special CE programmes are delivered is a source of deep frustration for clients.

Rehabilitation and re/integration should take place in a **calm and relaxed environment**, with space and scope for the range of work and activities that take place within Special CE programmes. Crowded, noisy and cramped premises are not conducive to intense therapeutic and developmental work.

Space needs to be made available to ensure privacy, particularly for counselling and any key working. Clients also need to be able to relax in a chill-out or meditation room and staff should also have access to a designated staff room. Ideally, premises should have a range of meeting rooms and classrooms to allow for both small groups and one-to-one work.

CHAPTER 7

EMERGING ISSUES

Methadone: a stalled project?

The research survey captured a range of views about methadone use.

There are major concerns about the administration of the Methadone Programme. There is also a deep unease about the over-reliance on methadone treatment and the absence of a comprehensive treatment infrastructure.

For some, methadone has worked and continues to work, changing the lives of individual clients in spite of the problems in how it is administered. For others, methadone is seen as a form of social control, a publicly funded addiction programme, an abdication of the state's responsibility and a substantial and immediate danger to our communities.

However, most would describe it as a '*stalled project*'. Rather than have methadone play a part in the initial stages of stabilisation and treatment, it has, more often than not, become the sole and final solution. The "one size fits all" approach is seen as failing clients. In this analysis, the problem is not with methadone use *per se*, but the lack of comprehensive, locally delivered treatment options.

The range of opinions

It is clear from the survey results that the majority of respondents believe that methadone has worked for individual clients. The survey findings showed high levels of support for what methadone has enabled and how individuals have managed to use methadone to stabilise their lives and to re/integrate. '*Children no longer have to watch parents shooting up, finding works in the sitting room – that's what Methadone has done*', to paraphrase one respondent.

Other respondents believe that methadone has been given a bad name and that the issue has become over-emotionalised. Methadone is not the problem, but the interaction with drugs such as benzodiazepines and sleeping tablets, they say. Clients should not have difficulties functioning if their prescription levels are right and if methadone is used correctly. *'If clients are goofing off it's because they are mixing it with other drugs'*.

The difficulties of managing detoxification and sustaining abstinence were cited as reasons for the long-term use of methadone being a more sustainable response. People remaining on low doses, such as 2-5 milligrams, and fully re/integrated for long periods of time, were cited as success stories.

Other respondents believe methadone is used as a means of reducing crime and making public order easier, not as a method by which to manage, or treat, addiction. They question how clients on high dosages of methadone, together with other prescribed drugs, can ever move forward and deal with their underlying dependency problems. Problem drug users will use drugs - prescription or otherwise - problematically. This will not change until the dependency issues are addressed.

The majority see methadone and treatment itself as having stalled. We are stuck with a situation in which methadone is treated as a permanent solution, an end point rather than a stage or step in recovery from addiction. As one respondent put it: *'Look at the European experience, Switzerland in particular - you can see that Ireland is stuck, still in the early phases, not able to move on'*.

Moreover, the fact that numbers in receipt of methadone are easily measured leads to what one respondent described as *'lazy treatment policies'*.

Changing drug use environment

Methadone, it is believed, cannot address the changing face of problem drug use. As non-opiate drug use soars and poly-drug use becomes the norm, the present treatment structures are not equipped to respond effectively:

'It's not about just heroin anymore. There is so much poly-drug use. Methadone is not the answer. We need wider treatment options'.

'The cocaine epidemic hits and what is the Health Board response? - "what is the substitute?" Not, how can we deal with problem drug use, but what can we give them instead to maintain social control?'

The increased acceptance of drug use was noted by all respondents. It calls for more harm minimisation and education work.

There are huge concerns about the use and overuse of prescription drugs, particularly benzodiazepines -an ongoing problem that has been raised throughout Dublin (for example Ballymun Youth Action Project, 2004).

There was some support for the decriminalisation of drugs as the only effective way of separating addiction from crime.

Disempowering communities

Community representatives are faced with high levels of disillusionment regarding methadone, on the one hand, and high levels of acceptance of the *status quo*, on the other, within communities and families of clients.

There is, however, a prevalent sense of failure. Mothers are reported as saying *'I thought it'd be great. He'd [her son] get on the methadone, return to normal, have a life. But what happened? He's up all night and in bed all day with the methadone. What has really changed'.*

Clients themselves believe they are powerless and voiceless in the treatment process and want, as patients, to play a more active role in decisions about their recovery. This is outlined in the chapter *Client Focus Groups* and put in the context of the need for interagency co-operation in the chapter *Interagency Working*.

The research clearly shows a demand for more action.

Treatment and catchment areas

Citywide (2005) found that the placement of drug treatment and drug rehabilitation within local communities is still highly divisive and contentious.

The experience of Dublin North East is more mixed:

'Its okay. The community's worst fears were not realised, the clinic didn't attract dealing, or people shooting up openly.'

'We have built up trust, they know what we do and that there is no danger, only benefits to the community.'

'We are still being watched, one wrong move and they will try to get us out'

There is a strong sense of local projects being needed for local people, of *'looking after our own first'*.

Community representatives are very aware of the demands to open up treatment beyond the existing catchment area. There is resentment that communities in the surrounding areas, who did not march or lobby for treatment, are now seeking to avail of the services built up within the communities that did.

Other communities are seen as being resistant to acknowledging that they have a problem, preferring to see it dealt with elsewhere.

'They didn't march, they weren't out on the street looking for treatment.'

'They need to look after their own, bring treatment services into their own areas.'

There is a recognition that communities who did agree to treatment facilities were, in some cases, given very strong guarantees as to what that would involve and who it would serve. No change can happen without widespread consultation.

Other community representatives see that the picture has changed, that there is more acceptance now of the treatment facilities, and that people do travel from outside the catchment area to avail of the services.

Special CE and catchment areas

Clients clearly stated a desire for flexibility in the catchment area criteria for participation on Special CE. The delivery of locally based supports is seen as essential. However, for some clients at different stages in their recovery, there is a need to break away from their familiar peer-group setting.

There are also occasions on which accessing one's local projects is neither possible nor desirable. This is particularly true when clients and staff are related or very well known to each other. In addition, the policy of some of the Special CE programmes to prohibit siblings from attending a particular group at the same time, while based on best practice, limits potential clients from participating.

Projects recognise the need to build on informal allowances currently made and believe that there is a case for change. Still, some also believe that the local community are not ready to accept it at this moment in time.

It is believed that, if separated from the treatment issues and restricted to those communities that have Special CE in place, it is possible to **both** assuage community fears and meet the needs of clients who wish to access Special CE outside their local area. This could be based on a limited pairing system within existing Special CE programmes to allow local people find the best place for their participation on Special CE.

Two of the projects expressed an interest in a review of the catchment area criteria and in looking at ways of co-operating to best meet clients' changing needs. Two others, while sympathetic to the problem, believe that there is strong community resistance to any change.

Legal Issues

Criminal convictions and employment

Many clients are simply unable to progress to the open labour market because of their criminal convictions. Respondents described how clients were in a legal limbo, ready to work but unable to secure employment, most notably within the public sector, as a result of their criminal records.

Community groups are seen as the best place to begin to overcome this and respondents call for an increased focus on employing former clients within drugs projects and other community-based work.

The research findings show strong support for a formal system of expunging the criminal records of problem drug users, who can demonstrate that they have rehabilitated, in order to remove barriers to accessing employment. It is understood that this would need to be managed in such a way as to reassure employers, and also to screen those with convictions for violence.

The Equality Authority, in their Review of the discriminatory grounds covered by the Employment Equality Act, 1998, call for criminal conviction grounds to be included in the legislation based, 'on the premise that discrimination against people on the grounds of their criminal record should only be permitted where the offence would be objectively incompatible with the requirements of the job' (Equality Authority, 2002:8).

Drug driving

Major concerns have been raised about the appropriateness of projects providing driving lessons and encouraging clients on methadone to apply for driving licences.

There appears to be a lack of understanding as to the legal status of methadone. Some respondents believe that driving with 40 milligrams or less is permitted. This is unrealistic, as dosage is dependent on individual tolerance levels.

The law would appear to take a totally prohibitive stance, with the charge of drunk driving applying to anyone with methadone in his/her system.

Whether methadone use invalidates car insurance has also been raised.

There are also concerns as to whether driving lessons, the costly activity of forklift driving specifically, actually lead to employment opportunities for clients.

Clients want to see learning to drive as a core part of the Special CE programme. Acquiring a driving licence, particularly for cranes or diggers, is seen as a marketable and practical skill that will stand to them and help secure employment.

For others, it is a way of regularising their previous driving history and is crucial to their re/integration.

Projects describe how driving promotes confidence and a real sense of achievement among clients, and say it is one of the most popular activities.

The issue of methadone use and driving and insurance needs to be raised at national policy level.

Unmet specialist counselling needs

Sexual assault, rape and childhood abuse

There is an acute shortage of fully qualified specialist counsellors available to clients in the Special CE programmes.

There are problems with referrals, as many specialist agencies - such as the Dublin Rape Crisis Centre - do not work with clients with active addictions.

Many of the clients are working with counsellors who are in the process of receiving their accreditation and may not have specialist training in the area, or sufficient experience. Clients also raised the issue that depending on volunteer counsellors or those working up their hours makes it hard to guarantee the long-term working relationship necessary to deal with issues such as childhood abuse.

Other respondents queried the nature of much of the counselling work that takes place within Special CE programmes. They would like to see a discussion on what counselling approaches and styles work with problem drug users and those in recovery. There was demand that counsellors move away from the "listening ear" approach to one of a more direct and challenging nature.

The research showed huge levels of concern about the inadequacy of Special CE responses as a whole. Staff spoke of being out of their depth, of not having sufficient supports to deal with disclosure. Other respondents raised concerns about inappropriate interventions and the possible long-term damage this can do to clients.

Even where staff in Special CE programmes are qualified as counsellors, there is a question as to whether they are best placed to counsel clients in the long term without changing the nature of the relationship.

There is an urgent need for counselling within Special CE to be funded and for quality assurance standards to be put in place at Task Force level, to ensure that clients have access to the range of specialist and long-term counselling supports needed.

Sexual exploitation and prostitution

Respondents report clients as having experienced high levels of sexual exploitation with many of the women and men having been engaged in prostitution as a means of supporting their addiction. Active problem drug users in contact with services are known to be involved in prostitution.

Services and projects report high levels of risk of sexual exploitation among problem drug users, particularly the under 18s.

This highlights the confusion that many people have between sex and sexual exploitation. There is a sense, among young people in particular, that oral sex is not sex and that forced sex is not rape. There is evidence of high levels of “swapping” -the exchange of sex for alcohol or drugs -a recognised progression path to more overt forms of prostitution.

One treatment clinic has made an attempt to bring in specialist advice and, at the time of the research, was facilitating a drop-in service to promote harm minimisation among women in prostitution.

Special CE programmes have also attempted to up-skill their staff in relation to the issue. Projects have brought in specialist agencies to talk about prostitution with the main focus being harm reduction/minimisation rather than recovery.

There is no clear referral system to specialist organisations working with prostitution in place, and projects are attempting to deal with the issues as they arise.

Staff spoke about the high levels of disclosure of prostitution and a lack of understanding of how best to proceed or to deal with the issue. This is equally true of disclosures of rape or childhood abuse. However, in this case there are at least minimum mechanisms in place to refer people to counsellors.

There is no clear understanding of what is involved in prostitution and how it is a process in and of itself from which clients need to recover. Projects require more training on prostitution and its long term impacts, and a closer working relationships with specialist organisations.

Homelessness

A number of the Special CE clients are or have been homeless. Accommodation issues were cited as one of the clients' major concerns, with many perceived as being at risk of homelessness.

Most of the supports for clients experiencing homelessness in Dublin are based in the city centre. This does not meet the need of clients who want to stay away from the city centre as part of their recovery. It also fails to meet the needs of clients who are rough sleepers in and around their local area.

Even those clients who have accessed hostel accommodation experience major difficulties maintaining hygiene and nutrition, finding it almost impossible to participate on Special CE.

There is a large homeless population living in and around Howth, sleeping rough in the woods and on empty boats. This highlights the need for homelessness facilities in the area.

More work is needed at Drugs Task Force level to determine the prevalence of homelessness, to lobby for facilities to be put in place and services expanded to Dublin North East.

The needs of Methadone patients in full-time occupations

Those Clients who do progress face problems in accessing the clinic at a time that accommodates their needs. This is especially true of fishermen and others who work irregular hours, but is also true of those working 9-5 within Dublin North East. They report major hurdles in accessing treatment without interfering with their jobs.

Clients spoke of having to leave jobs because of the problems of clinic access availability.

Clients also spoke of needing to buy methadone on the street, bringing them into contact with other street drugs and into the very environment they are specifically trying to avoid.

CHAPTER 8

RESTRUCTURING SPECIAL CE AS A REHABILITATION AND RE/INTEGRATION PROGRAMME

The research is an attempt to bring together a range of diverse voices, opinions and experiences - client, support worker, volunteer, funder, community representative, and service provider - across the Dublin North East Drugs Task Force as a whole.

A wide range of perspectives is encompassed by the research findings and a range of conflicting opinion within and across the four Special CE programmes and other stakeholders.

Survey results on the effectiveness of Special CE were very diverse and at times contradictory. Respondents believed it is not effective at all, but also that it needs to stay in place. Equally, some respondents believed it is the only programme to truly meet clients' needs, yet they also maintained that it could not, in its present format, tackle clients' priority issues.

For example, some respondents describe the unstructured nature of many of the Special CE programmes as creating '*a comfort zone*' for clients -cocooning them in a secure but unrealistic frame of mind -and failing to provide a proper orientation to the real world of work. Other respondents cite a lack of agreed referrals to ensure that progression is properly managed.

Still others claim that mainstream projects are not prepared to deal with all the complexity that goes with working with former or current problem drug users.

The truth is probably somewhere in between, highlighting the need to move to commonly agreed protocols on interagency working and what one respondent described as '*honest conversations and uncomfortable truths*'.

There is a deep sense of frustration and disappointment among respondents with how Special CE has failed to live up to its expectations, even when it is acknowledged that these expectations are misguided.

However, there is also pride and resilience in how it has managed to keep going, develop and change.

Special CE has been slated, dismissed, torn asunder and vilified only to be held up as an example of what can be achieved, of how lives can be stabilised and saved.

Those clients about to leave the programme were frightened and anxious about the loss that their moving on would represent, particularly the loss of income and routine. Leaving Special CE represents a loss of identity.

Meeting the challenges

The crux of the issue is not whether Special CE is or is not the appropriate mechanism for drug rehabilitation - it is agreed that it is not - but how best to meet the rehabilitative, educational and work-orientation needs of the clients.

The fact is that Special CE is established, that its services continue to exercise high levels of demand and that few alternatives to these services exist. The 2004 Bruce Review confirms that, for many participants, Community Employment is a key element in stabilising their daily activities.

Huge levels of learning have taken place and the structures are in place at community level. Any newly established programme will have to include all the key elements contained within Special CE and address the shortfalls and limitations highlighted in this and other research.

As such, Special CE is well-positioned to be redeveloped into a more cohesive rehabilitation and re/integration programme.

The challenge is to locate the best practice developed by Special CE and use it as the seed bed to grow an interagency re/integration framework.

However, this cannot be achieved in isolation. It must be placed in an interagency framework within a continuum of care model. This requires commonly agreed standards of best practice, together with interagency protocols. It also requires the funding and political will to make it happen.

Repositioning and restructuring needed

Problem drug users deserve a comprehensive rehabilitation-to-re/integration programme, set within an interagency framework. The skills and experience are there. What is needed is the will to bring it altogether.

There is invaluable and irreplaceable work being carried out. Good practice has been developed and development strategies implemented. Special CE can be developed into one core element operating within a continuum of care rehabilitation-to-re/integration model.

It is clear that no single agency has the expertise or structures to deliver effective and sustainable rehabilitation and re/integration programmes in isolation. Correspondingly, no single model of recovery and re/integration can suit all individuals.

Specific burdens regarding childcare, allowances, housing, health and imprisonment complicate personal goal setting. Many Special CE clients are exceptionally marginalised and disaffected, with profound feelings of worthlessness and exclusion. Personal care plans are needed to support individual progression. However, they cannot be delivered on in isolation within Special CE programmes. This task, by its very nature, is a multi-agency one.

A comprehensive programme of change is required in order to copper-fasten and mainstream the good practice that exists. Standards and quality assurances need upward harmonisation.

The reality of rehabilitation and re/integration needs to be acknowledged and by extension funded.

Staffing issues need to be addressed, core programme components put in place, and minimum standards of premises, facilities and services agreed upon.

Core supports, such as counselling, need quality assurance mechanisms established.

The programme requires more structure, to be delivered as part of a 5-7 year intervention programme, and to place a greater emphasis on measurable progression in basic adult education.

Communities that are lobbying for Special CE places could provide an opportunity for a restructured Special CE programme to be piloted.

Developing a demonstration model of rehabilitation and re/integration would provide agencies with a practical and focused goal. It would allow for chances to be taken, new approaches to be explored and new learning developed before long-term decisions are reached on the future role of rehabilitation work within Special CE.

Wider political landscape of rehabilitation and re/integration

Developing effective rehabilitation and re/integration programmes requires political change in a number of key areas.

Methadone treatment is a '*stalled project*'. Rather than have methadone play a part in the initial stages of stabilisation and treatment, it has, more often than not, become the sole and final solution. The "one size fits all" approach is seen as failing clients. In this analysis, the problem is not with methadone use *per se*, but with the lack of comprehensive, locally delivered, treatment options. A review of the long-term effectiveness of methadone is urgently required.

A formal system of expunging the criminal records of problem drug users who can demonstrate that they have rehabilitated is needed, in order to remove barriers to accessing employment. It is understood that this would need to be managed in such a way as to reassure employers, and also to screen those with convictions for violence and/or offences against the person.

CHAPTER 9

KEY RECOMMENDATIONS

The recommendations are grouped according to how they can best be actioned. Some recommendations are directed at Special CE programmes at local level, others at the Dublin North East Drugs Task Force, with some recommendations requiring action at national level.

Some of the actions at local level are beyond the scope of the Special CE programmes to act on in isolation. Many are dependent on funding and other supports so that they can be implemented. This is particularly true of the recommendations regarding staffing and support services. Significant structural change at Task Force or national level is required to address many of the research findings. All of the research recommendations require a change in thinking towards Special CE programmes.

The recommendations reflect best practice from the research and seek to bring about an upward harmonisation of commonly agreed minimum standards across the Drugs Task Force. As such, the CE programmes may already have many of the recommendations in place.

Some of the recommendations may require further consultation and refinement with Special CE programmes and projects through the Drugs Task Force. This is particularly true of the recommendations concerning referrals and programme delivery. This stipulation is set out in the grouping of the recommendations.

KEY RECOMMENDATIONS

PROGRAMME DELIVERY

REFERRALS

Local level

Multiple referrals points to Special CE programmes to be developed. Referral and intake should not be limited to those clients registered with methadone clinics. However, a clear mechanism and procedure for agreed and named referral points needs to be established to support Special CE programmes in meeting client needs for multiple referral points.

CATCHMENT CRITERIA

Drugs Task Force level

Support and facilitate the introduction of a **pairing system within Special CE** for those **existing** Special CE programmes that wish to support local clients in attending Special CE outside of their own area.

PROGRAMME COMPONENTS

Local level

Work towards **a cap on numbers** in any group work setting; for example, not more than 8 per group.

Balance between group work, small group work and individual classes to be written into the programme. Increase staffing and facilities funding to enable Special CE programmes to do so.

Provision of **separate men's and women's groups** on at least a once-weekly basis.

Consider delivering **separate provision for stabilised and poly-drug-using clients** for selected educational activities. Increase staffing and facilities funding to enable Special CE programmes to do so.

Rehabilitation programme to include **induction, core programme and move on** programme.

Core re/integration programme to be divided into **three distinct phases** with no automatic transfer from phase 1 to 2 or phase 2 to 3.

Training budget per Client to be significantly increased and to be attached to the individual. (The research suggests it needs to be in the region of 4,000 per annum.)

Literacy modules should be developed specifically for programmes with in-service training for staff, so that literacy can be built in across the programme work.

PROGRAMME COMPONENTS

Drugs Task Force level

Facilitate the development of literacy modules for the Special CE programmes.

STAFFING

Local level

Evaluate operation of staff **support and supervision**.

Develop policies on staff-client relations to address concerns raised about the need for clearly understood staff-client boundaries. This should be supported with professionally delivered staff training as part of the induction process and ongoing in-service staff development.

STAFFING

Drugs Task Force level

Fund and facilitate a review of staffing roles within drugs projects to produce:

- agreed target ratios of staff to client and qualified staff to trainees.
- a system of agreed grades, salary scales, qualifications, previous work, experience and responsibility levels for each staff member.
- an agreed job description for the role of key worker and support worker.
- minimum training, qualification and experience levels to become a key worker.

CE Support staff

Drugs Task Force level

Work to secure **appropriate funding for staff recruitment and development** on Special CE programmes.

Develop an **annualised plan of accredited staff training** and in-service for projects centrally co-ordinated and funded.

Develop a centrally co-ordinated three year training and development programme for CE Support Workers, with accredited core modules.

This should include clearly graded year-by-year training matched to work placement and responsibility levels. It should be based on existing accredited training and progression routes for addiction, youth work and community work, with pay scales matched to appropriate professional grades.

Promote a system of **work experience rotation** for Special CE Support Workers.

Review the possibility of introducing **progressive top up payments to CE Support Workers** to match increases in their skill development and responsibility levels.

Employment policies

Drugs Task Force level

Agree **guidelines and common standards of support and supervision for staff members** within Special CE programmes.

Explore the option of establishing an **Employee Assist Programme** at Task Force Level, in order to support Special CE programmes in meeting staff support needs.

Develop employment policies to cover **conflict of interest** and staff-client relations.

Develop a common policy on the employment of former clients on projects

Explore the option of introducing **positive discrimination** to promote gender balance among staff.

COUNSELLING

Drugs Task Force level

Develop **interagency protocols for commonly agreed standards of accreditation and minimum post-qualification experience** required for counsellors working with clients.

Source interagency funding for the provision of counselling hours.

Develop a **panel of qualified and accredited counsellors to be available to drugs projects**. These should be drawn from a range of counselling approaches and have specialist training and experience in priority issues identified in the research. This should not be limited to addiction issues. Clearly define and limit the scope and role of any counsellors working towards full accreditations who may work with clients.

Work with a specialist body to implement **vetting procedures, support and supervision centrally**, to be administered at Drugs Task Force level.

Agreed **minimum and maximum counselling hours** available per project per year to be evaluated on an annual basis.

PREMISES AND FACILITIES

Local level

Full kitchen facilities need to be available and at least one meal at day provided.

Kitchen facilities **should be separate from the main meeting or classroom areas** and act as a quiet space within the projects.

Provide **showers and washing machine**.

PREMISES AND FACILITIES

Drugs Task Force level

Agreed **minimum standards** of premises and range of facilities within Special CE.

HEALTH AND SAFETY

Local level

Review Health and Safety policies

HEALTH AND SAFETY

Drugs Task Force level

Develop agreed **protocols, policies and supported staff and client training on potential emergencies/hazards**, such as needle stick/sharp injuries, blood/body fluid born exposure, blood spill or overdose.

SUPPORT PROGRAMMES AND SERVICES

Local level

Outreach to be developed, including formalised links with and referrals from the prison and probation services.

Childcare provision to be made for school holidays and in-service training days.

Special CE services and facilities to be available to the **wider community**, where possible, as a means of integrating the programme and overcoming stigmatisation.

Aftercare to be provided with access to counselling and alternative therapies, as well as relapse prevention and peer support. This needs to accommodate the needs of former clients who may be in employment

Where **walk-in services** are not available as part of aftercare, clear referral systems to services on demand need to be established.

SUPPORT PROGRAMMES AND SERVICES

Drugs Task Force level

A **peer support programme** to be developed.

Develop a programme to act on need for **family support work** at local level.

Drop in, aftercare and out of hours service.

Carry out a needs analysis of **drop in, aftercare and out of hours services**, with a particular focus on the needs of methadone patients and others in full-time occupations.

Map current provision against demand and identify **strategy for development** responses across and at Drugs Task Force level.

Community detox facilities and respite
Drugs Task Force level

Carry out a **review of existing services**, mapped against the need identified in the research findings.

Community detox facilities and respite
National level

Increase the **number and range of community detox** facilities.

Develop and introduce a **system of respite at local level**.

INTERAGENCY WORKING

Local level

Service agreements to be developed with each funder.

Special CE programmes to submit an **annual plan**, with all sources of income cited and gaps in provision identified. This needs to be developed separately to interagency working.

INTERAGENCY WORKING

Drugs Task Force level

Promote the development of **an interagency initiative to underpin a coordinated and cooperative approach** to working with former and current problem drug users in Dublin North East.

Prioritise the development of an **interagency approach to treatment** that includes the service user.

Promote the development of an **abstinence-based intervention for education and training**.

INTERAGENCY PROTOCOLS

Local level

Develop comprehensive organisation-wide **confidentiality policy and protocols** with professionally delivered staff training.

INTERAGENCY PROTOCOLS

Drugs Task Force level

Agree protocols around **care planning**.

Build on the research findings to agree and implement common standards and methods of **assessments, progression reports and referrals**

Develop an **interagency system of referrals**, including a confidentiality protocol.

REPRESENTATION

Drugs Task Force level

Service User Forum to be staffed and funded.

Service User Forum representative to be elected to the Board.

Community representation reviewed with provision made for formal feedback and input mechanisms and the appointment of proxies.

Take action to address **non-participation** of statutory agencies, especially the CDVEC.

RESTRUCTURING AND EXPANDING SPECIAL CE

Drugs Task Force Level

Support projects to **empirically demonstrate the need for Special CE to be expanded.**

Support the **development of a re/integration model of Special CE** in areas where local demand exists, such as Howth or Bonnybrook/Fairfield/Riverside.

Develop a demonstration re/integration model of restructured Special CE as a means of expanding CE, an effective mechanism of implementing many of the research findings' recommendations and of piloting new practice.

RESTRUCTURING AND EXPANDING SPECIAL CE

National Level

Develop a comprehensive rehabilitation and re/integration framework, **including a restructuring of the current Special CE model**, to be delivered by an interagency National Rehabilitation Agency and directed by a high level ministerial working group.

This should include an **extended assessment phase, an induction phase, a core phase of no less than three years and a “move on phase”** of no less than two years.

Payment

National Level

In the short term, payments to Special CE participants to be **ring-fenced and excluded from means testing of secondary benefits.** Thresholds for income disregard to be increased.

In the medium term, develop a **more effective delivery method for CE payments**, as part of the restructuring of Special CE as a rehabilitation and re/integration programme, so that **payment is seen as a top up and does not affect other benefits.**

Employment

Develop ***sheltered employment options*** for those with dual diagnosis.

TREATMENT

Local level

More flexible Clinic **opening hours**.

To meet the expressed demand of Clients, monitoring of **urine samples needs to be available at least twice a week**. This must be **optional** and based on individual demand and conducted outside and separate to the operation of the Special CE programmes.

Treatment management team established in partnership with each of the Special CE programmes, clinical team and other relevant agency.

Explore range of **primary health needs** and means of local delivery.

TREATMENT

Drugs Task Force level

Review the current practice of benzodiazepine prescription on methadone treatment within a rehabilitative context in Dublin North East.

TREATMENT

National level

Review of treatment and the development of a comprehensive treatment, rehabilitation and re/integration framework.

Review of the effectiveness of methadone as a long-term treatment option.

EMERGING ISSUES

Prostitution

Drugs Task Force level

Working with specialist agencies, develop awareness of prostitution and its long-term impact, and means of making interventions and referrals.

Homelessness

Drugs Task Force level

Determine the prevalence of homelessness and lobby for facilities to be put in place and services expanded to Dublin North East.

Justice

National level

Introduce a means of expunging the criminal records of problem drug users who can demonstrate that they have rehabilitated, in order to remove barriers to accessing employment.

Clarify the legal status of driving while using methadone and other prescribed drugs.

FURTHER RESEARCH

Drugs Task Force level

Building on the prevalence study of drug use by young people in Kilbarrack, hold a Drugs Task Force-wide consultation meeting in order to **develop a strategy to deal with problem drug use among the under 18s.**

Develop an **area profile** of Dublin North East.

FURTHER CONSULTATION

Drugs Task Force level

It is recommended that the research findings be work-shopped before an implementation strategy is developed.

Those key stakeholders not involved in the initial consultation should be included before a final implementation plan is agreed

CHAPTER 10

Client Focus Groups

Priority issues

Income levels and interaction of Special CE with social welfare and other benefits

Most clients' priority need relates to how their Special CE payment interacts with secondary benefits. This affects rent allowance, fuel allowance, dietary allowance and back-to-school allowance.

Those in the private rented sector experience poor housing conditions. The system of rent allowance and the rent cap restricts the range of accommodation available. As one client put it '*[if you had proper rent allowance you] wouldn't have to live in damp dog boxes [and you could get] decent flats*'.

There is widespread frustration that their experience of Special CE is not "special" at all, and that commitments made in relation to their secondary payments being ring-fenced have not been kept.

The discretionary nature of secondary payments and the fact that the situation can seem to change from week to week and from one Community Welfare Officer to another is a huge source of anger and disempowerment.

Clients spoke of having secondary benefits clawed back with no advance notice and of seeing their real income levels drop, consequently feeling trapped in poverty with no way out.

Clients spoke of having benefits stopped once they began Special CE, losing entitlements one by one - free TV licence, fuel allowance, diet allowance - and having the household income cut back.

They spoke of their frustration of being trapped in a system that has not taken their special needs into account; the Catch 22 of having CE payments seen as income from work is that any other benefits are means-tested against it. Clients also fail to qualify for FIS (Family Income Support) if they are on Special CE, which is not considered as being in employment in this case.

There is a need for income thresholds to be higher and for clients to be given the time and space to catch up financially. There are also calls for the means testing of Special CE income to be stopped.

The fact that different clients could be in receipt of different payments, and so different income levels, was also a major source of frustration and tension. Particularly in cases where, for example, the same Community Welfare Officer refused one client rent allowance but afforded it to another client on the same Special CE programme.

Having the issue of rent allowances resolved would make a huge difference to clients' progression on Special CE.

As one client put it – *'you wouldn't be under stress all the time and you could get on with your life'*.

The financial incentive of being on Special CE is seen as hugely important as it helps clients move away from illicit activities and supports increased stability in their lives. As one client said, *'I feel better about myself now, I want to take an interest in how I look, but that costs money.'*

Others spoke of how the work (on the Special CE programme) could be very challenging and emotionally tiring, but knowing *'I'd be docked gets me up and in here in the mornings, and then it's never as bad as I thought once I'm in'*.

Medical issues

The client focus groups highlighted the huge levels of frustration with how their treatment on methadone is managed, and the lack of influence or control clients believe they have in the process. This echoes the findings of other research with service users (see UISCE, 2003, for example) highlighting how powerless methadone users feel about decisions taken in relation to their drug treatment.

As one client explained: *'The doctor has our lives upside down. He is never there when you need to see him. He has no time for the people he is meant to care for'*.

Across the four Special CE programmes, clients spoke of themselves or others being treated with disrespect by the medical staff, of not being involved in their own treatment and of having their attempts to reduce their dosage and/or to detox completely frustrated. This confirms other research findings that show that methadone patients are rarely seen as a consumer (UISCE, 2003:10).

During the client focus groups, clients spoke of how it is *'all down to the doctor – he doesn't like you and that's it'*. Concerns were voiced at the lack of a cohesive policy on detox within and across treatment clinics, of inappropriate screening, of a lack of flexibility with clinic times, of an absence of an emergency/out-of-hours service, and of the medical personnel not having a good enough understanding of drug issues.

Clients across each of the projects described themselves or others attempting to negotiate detoxing from their prescribed medication only to have the dosage increased. This is a huge source of frustration leading to apathy and despair.

The clients want to see more specialised training for prescribing doctors, respect and dignity training for all clinical staff, and a treatment team approach where they and their advocates have a say in treatment decisions.

A need for doctors to deal with more than just prescribing methadone and to address related health problems such as abscesses and general well being is evident. This means that clients need to have more time with doctors and that a stronger doctor-patient relationship must be encouraged. Some clients want to have better access to prescribed benzodiazepines - so as that they don't have to buy them on the street. As already stated, such activity brings them into contact with other types of drugs (both licit and illicit).

Overall, there is a need for a more patient-centred approach. As clients put it:

'Doctors should be good listeners and not just presume that all clients are the same'.

'[I want a] proper assessment and not an assumption that I'm just another junkie looking for more ways to get stoned.'

Clients want to see more flexible clinic opening times made available. The needs of working clients need to be accommodated.

Clients would like to have the **option** of urine samples being taken twice or three times a week. *'When it's once a week I know how to get round it... twice or three times a week and I can't.... Then my head is free of all that and I can get on with what I'm trying to do'* [stay off opiates and other illicit drugs]. While recognising that urine testing is - by its very nature - an external control, clients believe it strengthens their internal motivations.

The lack of an effective complaints procedure within the treatment clinics and the fear - justified or otherwise - of sanctions, was evident during the Focus Groups.

As one client said, *'the power is where the drug is'* - summing up clients' belief that if they do complain they are putting their access to medication at risk.

The perceived lack of confidentiality within clinics and the fear that information provided to the drugs counsellor within the clinic will affect their methadone prescription, reinforces the need for a separate panel of drugs counsellors external to the clinics.

Clients want to be able to stay with their own GP if they want and not have to be on the clinic to access Special CE.

Clients want to see more treatment alternatives, particularly residential and respite treatments.

Accommodation

Clients experience huge difficulties with accommodation. As well as the issues with rent allowance cited above, they experience problems of poor quality housing, insecure tenancies and overcrowding.

They are at high risk of homelessness or are still experiencing homelessness. This makes it very difficult to focus on the Special CE programme. Some have been homeless for over five years and feel that, as a drug user, they are way down the housing priority list.

Clients want to see more help with housing re/settlement and more options for transitional housing.

At times, clients also need time out and want to see more respite facilities within their own area for short stays.

Childcare

There is a need for more childcare provision, particularly on midterm breaks and during the summer.

There was also criticism of the lack of leeway regarding payment when a child is sick or the childcare centre is closed.

Other clients would like to see more activities that children can be included in.

Greater awareness of addiction

There is a need for agencies and individual staff to be more aware of addiction issues. Talking about how she feels treated by social welfare one client says:

'To be treated like a person and not a piece of dirt and to let you make a fresh start and not to be judged on what you were before' [is what she desires].

Premises

More space is needed for the work. In some of the projects there is little or no privacy. Privacy (and so, space) is needed for counselling, work with the key worker and sometimes just for a break *'from the madness'*.

A meditation/chill-out room and more room for artwork have been suggested.

More room is also required so that different classes can be run in parallel and so that not all clients have to do the same activities.

All clients wanted to see increased kitchen facilities and, in those projects where breakfast or lunch was not available, there were calls for this service to be put in place.

Clients also wanted to have showers and washing machines available on site.

They would like to see better sharing of facilities and co-operation across the Special CE programmes, including shared activities.

Some clients wanted to have gym facilities on site.

All wanted better access to computers.

Programme evaluation

Clients have a mixed relationship with Special CE. From the Focus Groups it was clear that many have benefited significantly from participation on the programme. They spoke in glowing terms of what they had achieved, how far they had come and what they had learnt.

Clients described CE as providing the opportunity to develop self-confidence, pride and a sense of dignity. They related that participation in the project has led to real change in their lives.

However, clients also spoke of their frustration at how little progress they seem to have made in education and training terms, and how few move-on options were open to them.

Clients who were about to leave the programme were frightened and anxious about the loss that represented, particularly the loss of income and loss of routine.

Others spoke of how being on CE is seen as having a job that neighbours would ask of - 'how are you getting on in the job?' - and that it is hard for them to think of going back to nothing. Leaving Special CE represents a loss of identity.

Missed opportunities

All Clients wanted to see more structure and planning in programme delivery.

The system of ground rules was criticised and praised in equal amounts.

All of the clients were participating on Special CE programmes and on methadone maintenance, therefore engaging with service providers and support groups. As such, they come from what Vanwesenbeeck (1994) calls the “between group”, and do not reflect the full spectrum of experience of drug use and rehabilitation.

The majority of clients were in their third and in some case fourth year on Special CE. This means that the group were looking back at the experience with a lot of wishful thinking, a sense of missed opportunities and a very real fear of what lay ahead.

‘If I had my time again...’

‘I’m only getting myself sorted now, I only feel I know what I want to do now and my time is up.’

‘Its all just coming together and [I’m] finished [on the programme].’

Education and training

Clients spoke of the need to balance individual interests and needs more. They felt that there is too much emphasis on group work, which can be boring if the subject matter doesn't suit individuals.

There needs to be more small group work so there is more subject choice and not just a case *'of everyone having to do art'*.

The mixed educational backgrounds on the programme need to be recognised.

There is a need for more literacy supports, particularly one-to-one work.

'I'm here years but I still need help with my writing.'

'I have problems with my spelling, I thought I'd learn more here.'

Equally Clients described others who have overcome literacy issues through support on the project and doing one-to-one classes externally:

'He's still at it, doing really well.'

There needs to be more clarity about what training will and won't be funded and when to expect funding decisions. Training needs to be paced throughout the programme and not all be *'focussed in the last six months'*.

There is acknowledgement that things have improved on the Special CE programmes, but resentment remains that so much time was wasted in previous years when little or no training was made available.

Staffing and supports

Clients want to see full-time fully qualified staff and higher staff numbers, so that they can have more individual attention.

There was some resentment that many of the workers were on CE as well and some not fully qualified or experienced. They questioned why problem drug users should have lower standards of staffing than '*someone in care or in prison*'. This scenario was seen as conveying a lack of respect for problem drug users on the part of authorities, and demonstrating how low they believe they are on the political agenda.

Clients raised the issue of conflicts of interest with staff and the need for more boundaries, citing examples of when, as they describe it, staff had made inappropriate interventions outside of the programme.

Yet they were very defensive about the projects, protective of project staff and insistent that CE support workers need to continue on the programme.

They also want to see more wages and better training for CE support workers.

There is a need for more counselling, both drop-in and by appointment. Counselling that is external to the projects and clinics was stressed as a preferred option. There is a need for counsellors who are fully qualified and have long-term training. There is also a need for consistency with counsellors, so that clients expect to work with the same counsellor throughout their programme.

There is strong support for alternative therapies and a wish to keep having the option of attending them as part of aftercare.

There is a need for an out-of-hours service.

Overcoming stigma

Clients spoke of how central the CE programmes are to their recovery, how their self-confidence has improved, how they *'walk tall'*, *'how 'people in the shops don't even notice. They'll tell me how great I'm looking and how well I'm doing.'*

The difficulty of dealing with the stigma of having been a drug user and how central CE is to this process is evident in the most mundane of daily events:

'People see you getting up, leaving the kids to school, going to your job, you get their respect.'

Clients describe how encouraging it is for family and neighbours to see them *'Getting up and coming into the job'* [Special CE].

Clients describe being able to walk into a shop with their *'heads held high, not being followed'*.

'As a father, on sickness benefits, starting a course made me feel like a man, but I was shocked to lose my entitlements.'

In terms of moving on from Special CE, clients felt that the project names meant that people were always aware of their past and that it didn't look good on CVs.

Programme length

The programme length of three years is simply not enough.

As one client put it, *'I was using for over ten years, I'm seven years on the clinic and they expect me to get my act together in just three years [on Special CE]'*.

Clients want to see a five-seven year programme in place, *'the same as secondary school if I'd gone'*.

Programme structure

Clients cite the need for different phases of rehabilitation and re/integration programmes. They believe that “pre CE” - that is, an induction programme - is essential so they *‘can get stuff sorted, out of the way so you can cope with the [core CE] programme’*.

They believe the Special CE should have three distinct phases, moving from rehabilitation to more of a re/integration. Their ideas for the programme components are listed in the appendices.

They want to see more work placement and work experience built into the programme. Furthermore, they believe that structured move-on options are essential.

Some clients believe that payments should be increased as part of the progression.

Others would like to see programme length linked to the methadone programme, so that they would finish the two at the same time. One client explained that:

‘It would make a big difference to me, to sort out my life properly and not end up back in the circle.’

There is a real fear that, by only having three years on the programme, those clients who are not ready to leave will go back on drugs.

As one client put it: *‘I’m clean. To get where I am took me five years. So many people give up after a while’*.

Clients also want it to be easier to get back on the programme if they have relapsed, or to be able to take time out if they need to without losing their place.

Mixed levels of stability

The problem of clients being at different stages of recovery - with some stabilised on methadone and others poly-drug-using - was highlighted. Clients described how hard it is to focus in this environment, saying how trying it is to be on the project *'just on your methadone and others are dabbling; it gets you down'*.

It should be different for everybody. People that are trying to come off methadone and [get] clean from street drugs and really doing it [should be rewarded].'

Clients spoke of their frustration at having to stay in what they describe as a drug-using atmosphere if they wished to receive the supports that accrued from CE.

There was widespread support for a "drug free" - meaning abstinence-based - programme.

Local projects for local people?

The importance of having the projects based locally was highlighted, with more community involvement requested. Clients liked that local people also used the facilities so they were not ghettoised.

However, other clients felt that by being so local it was like *'being in a fish bowl, everyone knows your business'*.

This was linked to the perceived lack of confidentiality within the projects, whereby: *'if you have a row in the job [the Special CE programme] everyone out there [in the wider community] knows about it. You can't have family members working here; it gets too mixed up. Everyone knows your business.'*

Catchment area requirement

Some clients also believed that being locally based was not always good for recovery. As one client explained:

'I grew up here, I started taking drugs here, I took drugs with these people, I robbed with these people, I robbed these people. For my next step I'd like to move away from the group.'

Others spoke of Special CE being a *'drug club'* and of wanting to be involved in more activities outside their own immediate local area.

Others spoke of how potential clients are being prevented from coming on the programme by "just being one road down", that is, just marginally out of the catchment area.

Others would just prefer to see a better mix of people. *'You get sick of it, seeing the same people day in day out, at the shops, at the schools, here at work [Special CE]. It'd be nice to travel to classes, move out of the area too.'*

More out-of-hours services and social activities

There is a need for more social activities available out-of-hours and at weekends. *'If there was a drop in centre it would give me something to look forward to.'*

Clients spoke of it being *'very hard to fill the time'* and of *'going home shutting the door and not leaving again till it's time for work [the Special CE programme]; that's how scared I am [of relapse].'*

Some wanted gym facilities within the projects.

Support groups

Clients want to see more structured support groups and opportunities for peer work.

There were very mixed experiences of NA, with women being reluctant to attend mixed groups and others speaking of drugs being widely available at the meetings. They complained that the atmosphere was not one conducive to those attempting recovery. Others spoke of how they see *'the same faces at NA as when I was using and they are up to the same stuff. I stopped going'*.

However, for some clients NA has been a good support.

There is strong support for the Service User Forum.

Accessing employment

Clients want to see a more practical focus on training, such as driving licences and safety passes.

'I want to get to work fast. To get off drugs and back to working for a better life before my daughter ever finds out I was on drugs, and to make her future brighter and safer'.

Clients repeatedly cited the failure to achieve sufficient levels of literacy on completing the programme.

There is a need for more work placements, with some asking that the final year of the programme be more exclusively focussed on work placements.

Other expressed an interest in becoming support workers or in becoming involved in youth work.

In terms of progression from Special CE, clients spoke of being frustrated by their previous convictions, and of how accessing employment is now problematic, even in the public service.

Most of all, clients want to be leaving with more formal qualifications: *'Three years here and I'm leaving with nothing, they tell me there's no money for the course I want to do. I'm heading back to the labour'*.

Aftercare

There is a strong need for aftercare.

Clients expressed fears that when they leave Special CE they lose childcare funding.

Clients want to continue in counselling after they leave Special CE and need to have that funded.

There was a wish to continue with alternative therapies.

Clients want to see peer support (outside of NA) in place as part of an aftercare programme.

Move on

Clients want to see a structured "move on" programme.

They believe that they need at least two years after Special CE to get the skills and training for the open labour market.

Some would like to see it delivered as part of the CE programme, whereas others would like to access mainstream CE or other forms of supported employment. Some want to get into mainstream education but have aftercare supports from the drugs project.

Some just wanted to move on.

As one Client said: *'I'm sick of drugs, talking about drugs, it all being about drugs. I needed my time here, but I can't wait till I'm in a class and just talking about normal things.'*

Operational issues

Clients want to be able to stay with their own GP and not have to be in a clinic to access Special CE.

Clients want to see "drug free options" and not to have to be on methadone to access Special CE.

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Submission from Citywide to Mid Term Review of the National Drugs Strategy,
September 2004

Presentation to Dublin North East Drugs Task Force by the Service Users Forum

APPENDICES

Appendix 1

Developing a shared understanding

Survey feedback on rehabilitation

The following were cited as key elements of rehabilitation:

A place of safety, support, and respite

Somewhere to be listened to and to belong

Somewhere to be challenged

Recognising own needs

Providing space for personal development, to increase self-esteem, self-image, and confidence with self and others, facilitating the ability to be proud

Setting goals and naming milestones

The recognition of skills, talents, and potential

An opportunity for change, to create a new lifestyle

Providing positive alternatives to drug use

Learning to engage

The possibility to create, repair and sustain relationships (personal, with family of origin, and/or with children)

The possibility to develop positive relationships with agencies

The opportunity to have outstanding issues (e.g. health, justice, housing) case managed and resolved

Support to overcome stigma

Recognising what has been lost and can be gained

The opportunity to address the harm done by drugs

Rebuilding trust

Learning how to change

The ability to take control

Getting to a point where drug use no longer defines you

About overcoming dependency and re/gaining a capacity for daily life

Opportunity to reduce drug use

Learning to be drug free

Learning harm minimisation, staying alive!

To support the physical recovery from drugs, gain weight, improve nutrition

Availability of interventions, supports and services

Increased income

Building a bridge to education and training

Access to job coaching

Access to social activities

Access to employment

Appendix 2

Developing a shared understanding

Survey feedback on progression

These are not definitive but reflect the priorities of the respondents and the overall research findings.

Routine building

Ability to attend programme on time

Ability to participate in classes and to concentrate for (1 hour, 2 hours, 3 hours)

Ability to attend appointments

Social skills

Non-confrontational interpersonal skills

Ability to take part in group activities (taking turns, showing consideration)

Ability to manage difficult situations

Ability to articulate own case

Listening skills

Responding to complaints

Knowing when to disclose and when not

Modifying behaviour to suit social setting

Personal development

Developing an interest, (re)discovering a talent (e.g. Art, IT, English)

Improved self-esteem

Goal setting

Dealing with failure

Establishing priorities

Establishing boundaries

Understanding confidentiality

Self-directed learning

Self care

Taking pride in appearance

Developing harm minimisation strategies

Developing relapse prevention strategies

Developing coping skills

Looking after health, managing on-going health problems

Maintaining emotional health

Eating properly

Relaxation

External and significant relationships

Improved family relationships

Improved parenting skills

Level of family engagement and support

Developing an external support network

Developing positive relationships with state agencies (housing, social service, schools)

Education

Concentrating on a task

Completing assignments

Improved literacy

Improved numeracy

Achieving accredited training (FETAC, ECDL)

Work orientation

Ability to apply for a course/job

Ability to attend for interview

Completing work experience/work placement

Entering mainstream education or training

Entering formal labour market

Other issues

Debt/Budget management

Being in suitable accommodation

Dealing with legal issues

Appendix 3

Developing a shared understanding

Survey feedback on stability

Being in education or work

Being positively occupied

Ability to access mainstream services

To have a legitimate identity

Break away from old lifestyle, clinic

Not involved in illicit activities

Back in family home

Create an “ex role”, new supports, new peers

Being able to walk into a shop without being followed

Have and sustain a positive intimate relationship

Have and sustain a positive relationship with children

Take care of children, doing homework with children, collect from school, take responsibility for children’s welfare

Have a support network (outside of project)

Emotional stability

Able to relax and enjoy yourself without drugs

Able to deal with pain and manage a crisis

Eating regularly

Take care of health: physical and emotional

Pay bills, manage money

In secure housing

Being independent

Involved in community

Develop interests from Church to sport to creative arts

Having spiritual dimension

Appendix 4

Developing a shared understanding

Survey feedback on assessment process

These are not definitive but reflect the priorities of the respondents and the overall research findings.

Accommodation, current housing needs and history

Family status/issues, and care arrangements of child/ren

Health status, health management and current medical needs

Legal status, and community issues

Income source/s

Financial issues and debt management priorities

External and significant relationships and peer groups

Relationships with agencies and support networks

Educational background, training and employment history, literacy levels, and education and training needs

Drug history, current and previous treatment, medication levels, and current drug use (prescribed and other)

Social skills, coping skills, and behavioural patterns

Appendix 5

Developing a shared understanding

Survey feedback on interagency system of referrals

These are not definitive but reflect the priorities of the respondents and the overall research findings.

Personal status

Significant relationships

Child/ren care arrangements

Source of income

Social skills

Patterns of behaviours and coping skills

Level of interaction and participation in programme

Level of interaction with peers and staff

Challenges that may arise

Education and training needs (where relevant)

Educational background

Training and employment history

Literacy levels

Education and training needs

Outstanding issues

Accommodation issues

Treatment issues

(include dates and times of regular and upcoming appointments and names of relevant contact people)

Immediate health concerns that may impact on ability to participate

(include dates and times of regular and upcoming appointments)

Immediate legal issues that may impact on ability to participate

(include any court appearances outstanding, details of probation orders)

Appendix 6

Client feedback on phased programme content

Induction

Stabilisation

From street drugs to prescribed drugs only

Harm reduction

Accommodation issues

Induction, getting to know staff

Routine

Assessment, finding the fit

Phase 1

Induction

Learning the structure

Finding your feet, becoming grounded

Establishing ground rules

Maintaining time-keeping

Assessment

Getting to know your Key Worker/Support Worker

Identify ancillary issues and prioritise

Family supports

Childcare arrangements

Dealing with accommodation issues

Start to address medical/dental issues

Relationship building

Stabilisation
Harm reduction
Drug awareness

Find your own motivation (not just urines)
Relapse prevention
Group therapy
Individual counselling (if required)

Health awareness/promotion
Keeping fit
Nutrition
Keeping occupied

Interpersonal skills
Communications
Learning about respect and boundaries
Life skills

Identify individual training needs
Begin one-to-one training
Access information on outside training

Phase 2
(core elements of phase 1 also continue)

Structures become a habit, sanctions versus flexibility

Start detox, reducing dosage
Drug awareness
Relapse prevention
Individual counselling (start to focus on)

Keep fit
Alternative therapies
Alternative social activities

Education
Literacy
Optional and Core modules of training
One to one classes
External training
Information Technology
Driving lessons/licence

Family supports
Relationship building
Parenting

Phase 3
(core elements of phase 2 also continue)

Individual programme
Develop personal control
Individual counselling

Start detox, reducing dosage
Letting go, leaving the comfort zone
Move on preparation

Job preparation
Get to know Jobs Club facilitator
Mock interviews
Work placements and experience

Practical training
Intensive training
External training
Identifying further education/training needs

Budgeting

Secure Garda clearance
Resolve all outstanding legal issues
Secure [car] insurance

Develop peer support, social networks
Develop external supports
Finding alternatives, creating an “ex role”

Look at housing options
Become linked into services (housing, education, LES)

More on programme (1-2 years)

Detox

Relapse prevention
Counselling
Peer support

Sorting out childcare

Further education
Training
Work placements
Community Employment
Jobs Clubs

Follow on/Aftercare Year 4-6

Individual counselling

Relapse prevention

Group work

Peer support

Alternative therapies

Childcare

Social activities

Mainstream Community Employment

Structured training work placements

Further education

Appendix 7

Key Stakeholders and informants identified for consultation and formal interview

Special Community Employment Programmes

DONNYCARNEY YOUTH PROJECT
EDENMORE DRUG INTERVENTION
KILBARRACK COASTAL COMMUNITIES PROGRAMMES
REHABILITATION ADVENTURE SPORTS PROGRAMME

Local Drugs Projects without Special CE programmes

ANA WIM, KILMORE DRUG AWARENESS
ARTANE DRUG AWARENESS PROGRAMME
BONNYBROOK FAIRFIELD RIVERSIDE DRUG AWARENESS
DARNDALE BELCAMP DRUG AWARENESS
HOWTH DRUG AWARENESS

Locally based initiatives and individuals represented on the Board of Dublin North East Drugs Task Force

NORTHSIDE COUNSELLING SERVICES
MIC PROJECT
ST. MONICA'S YOUTH CENTRE
CLLR. LARRY O' TOOLE

Statutory bodies

BELDALE VIEW TREATMENT CENTRE
COLAISTE DHULAIGH
DUBLIN CITY COUNCIL
FAS
AN GARDA SÌOCHANA
KILBARRACK SATELLITE CLINIC
NORTHERN AREA HEALTH BOARD OUTREACH TEAM
PROBATION & WELFARE
REHABILITATION AND INTEGRATION SERVICE

Interagency stakeholders

DUBLIN NORTH EAST DRUGS TASK FORCE
NATIONAL DRUGS STRATEGY
NORTHSIDE PARTNERSHIP

Other key informants and models of best practice consulted

ARC: ADDICTION RESPONSE CRUMLIN
ACRG: AFTER CARE RECOVERY GROUP
BLANCHARDSTOWN DRUGS TASK FORCE
CITY WIDE
CROSSCARE
FINGLAS CABRA DRUGS TASK FORCE
SAOL PROJECT
RIALTO COMMUNITY DRUGS TEAM