Youthwork as a Response to Drugs Issues in the Community

A Report on the Gurranabraher –Churchfield Drugs Outreach Project; Profile, Evaluation, and Future Development

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Dedicated to the Memory of Helen Duggan,
School of Applied Social Sciences.

Youth Work Ireland Cork

Cumann Spraoi Limited, trading as Youth Work Ireland Cork, is a company limited by guarantee and a registered charity. A voluntary Board of Directors are responsible for the overall management of the company. Youth Work Ireland Cork is a charitable not for profit youth organisation working with young people in Cork City. Youth Work Ireland Cork is a member Youth Service of Youth Work Ireland (formerly the National Youth Federation).

<u>Mission</u>

To provide a community based response to young people's needs by offering them the opportunity to contribute to and participate in social education, artistic and recreational activities.

The approach of YWIC offers an integration of services in the community by providing young people with:

- A creative outlet
- Opportunities to develop their social skills
- Information to young people and adults on related issues
- Developing community services links with schools, agencies and sports clubs
- Supports for parents
- Developing a family network
- Allowing young people to become their own advocates
- Supporting young people in becoming politicized

http://www.ywicork.com/index.htm

The City of Cork Vocational Education Committee (VEC) and the Cork Local Drugs Task Force are the primary funders of Youth Work Ireland Cork's interventions in the Gurranabraher-Churchfield area.

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The School of Applied Social Studies, UCC, is a centre of excellence in the Social Sciences and has been recognised by the Council of Europe for its pioneering educational achievements. In the past 19 years, it has grown to become one of the biggest Schools within UCC's College of Arts, Celtic Studies and Social Sciences. Its academic structure is complex, comprising social policy, applied social research, social work and community development and youth work. It also contributes to teaching in health, early childhood studies, government, environment and planning.

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Executive Summary

The issues stemming from the use of drugs in contemporary Irish society are a continuing source of grave concern for policy makers, communities, law enforcement agencies and various professional practitioners.

The evidence generated from this research study strongly indicates that community based, youth work informed drugs interventions can provide a comprehensive set of services to drug users within their own neighbourhoods.

The key findings from this study are;

- A social rather than medical or legal based response to drugs issues offers policy makers and practitioners a genuinely holistic methodology for effective intervention
- A local rather than universal response rooted in harm reduction allows for cultural, geographical and community factors to dictate the nature of an intervention
- Effective praxis in this field requires skilled, independent, reflexive, motivated and creative practitioners operating within a supportive agency setting
- A clear theoretical framework encompassing knowledge of young people, drugs work, human behaviour and communities is a fundamental prerequisite to best practice
- A high degree of service visibility in the community and easy access to the services is required
- Community based projects work effectively with service users who will never enter treatment; they offer drug users an effective alternative to medicalised responses

- In many cases inappropriate and problem drug use is a consequence of social inequality; interventions that can respond to these social issues in (particularly disadvantaged) communities offer the people who suffer from drugs issues a far more comprehensive range of services than a medicalised response.
- Human contact between the service user and the practitioner in the form of a relationship founded on trust is the key building block of success
- In terms of cost effectiveness community based projects offer excellent value for money; the overwhelming majority of funding is used in the provision of frontline services and the per-capita costs compare very favourably to other forms of intervention.

As Ireland enters into a period of austerity measures and cutbacks in services it would be imprudent to view Drugs Task Force Projects as a luxury service that can be done without or scaled down. Indeed in the context of recession the likelihood is that drug consumption will increase rather than fall as people attempt to cope with unemployment and loss of income. In its annual report for 2010 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) state that;

> *"It is too early to predict what impact the economic crisis will have on drug use in Europe – but we know that marginalized and socially disadvantaged communities are the hardest hit by drug problems. Services for drug users are increasingly threatened by budget cuts, which could have a detrimental effect, not only on*

> *those who use drugs, but also on the communities in which they live"* (EMCDDA, 2010, p.5).

It is in times of economic hardship that the funding to interventions based in marginalized communities need more than ever to be maintained, not cut. Fintan O'Toole has recently pointed out the fallacy of 'slash and burn' economics in relation to services; "*cutting drug treatment in the community means we'll end up doing it in prison – at a multiple of the cost*" (Irish Times, 7/12/10).

The choices we may take in examining drug issues are clear;

> *"For everybody who has an interest in the prevention of drug and alcohol problems the options are clear: either we engage with and accept complexity or we pretend that the issues are simple and straightforward"* (Butler, 2002, p.10).

This research study incorporates the view that drug issues are complex and varied, they therefore demand an equally complex and varied range of responses.

Chapter 1; Introduction

Introduction

This report is an evaluation of the Gurranabraher/Churchfield Drugs Outreach Project (GCDOP), sponsored by Youth Work Ireland Cork (YWIC). This project has been taken as a case study to exemplify the nature and form that youth work sponsored drugs task force projects can take in contemporary Ireland. The research evaluates whether this project offers learning and examples of best practice in the area of drugs work[1] in disadvantaged localities through the development of a locally orientated praxis that is congruent with policy and international best practice in this field.

The report is structured in the following manner;
Chapter 1 introduces the background, rationale and methodology of the study

Chapter 2 explores the contextual background and reviews the pertinent aspects of the origins and development of the Drugs Task Forces, young people's drug use, Irish drugs policy and the impact of social exclusion on drugs use.

Chapter 3 looks at the contemporary landscape from a youth and community perspective in terms of the responses, interventions and issues that influence the nature and form that current service delivery takes. It also (briefly) outlines potential changes in the drugs ecology.

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[1] It should be noted that any reference to drugs in this report includes alcohol (a particularly potent substance that has belatedly earned the title of a 'drug' under the 2008-2016 National Drugs Strategy).

Chapter 4 profiles the Gurranabraher-Churchfield Drugs Outreach Project and the neighbourhood in which it is located. This chapter details the development of the sponsoring organisation and the drugs project; it outlines the structure, management, staff, service users, substances used, vision, theory and practice of the intervention.

Chapter 5 evaluates the project's work against key criterion; the project's aims, the mission of the sponsoring agency, the National Drugs Strategy, the local drugs strategy, the National Youthwork Development Plan, the viewpoint of the service users and the impact of the project on the local community.

Chapter 6 is a brief examination of the feasibility of expanding the project's operations.

Chapter 7 is the concluding chapter; it summarises the key features that, from the community-youthwork perspective, represents best praxis in drugs work. Thereafter, it presents the overall conclusions from this research study.

Throughout this report the meta-analysis adopted is that the use of psychoactive drugs and the issues that arise from such use are predominantly social phenomena; in line with this approach other considerations (such as legal and medical) assume a secondary position and consequently best policy and practice are rooted in a social analysis of the subject matter.

Rationale

This study originated from discussions held within Youth Work Ireland Cork concerning;

1. the seemingly precarious nature of resourcing in the current economic climate[2]
2. the perception that the drugs work conducted in the project was of a very high standard and worthy of evaluation
3. a perception that other agents (particularly state actors) do not fully grasp the nature, context, challenges and successes of the community youth approach to drug use
4. the growing perception amongst youth and community work organisations that their contributions to this area are undervalued, with the consequential fear that resources would be diverted into other (medical-legal) responses
5. the growth of an inappropriate ‘numerical referral’ approach to evaluating the work that views the transference of ‘clients’ up the tier[3] system as an indication of success

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[2] The project under investigation in this study has been alerted to the fact that its budget for 2011 will be reduced by approximately 2%.

[3] The tier system allocates services users to various services on a more or less medicalised model of low to high specialism with (for example) outreach services being tier 1 (low) and residential rehabilitation therapy tier 4 (high). The system presupposes that ‘clients’ will be referred from the lower tiers. There is anecdotal evidence that low tier service providers are not satisfied with this system as it also presupposes a hierarchy of expertise and relegates valuable work to a low-skill/low status position. The Gurranabraher-Churchfield project’s service users straddle the entirety of the tier system.

On foot of these discussions it was decided to formalise a dedicated research project; in order to minimise costs it was further decided that the study would take the form of an internal evaluation. In this regard the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) note that;

> "*Internal evaluators may be more familiar with the intervention and its processes than an external evaluator and may be more likely to enjoy the trust of staff and gain access to useful informal information…. Furthermore, internal evaluations are less expensive than external ones and for this reason can be considered when budgetary resources are scarce but evaluation is considered necessary* (2007, p.19).

Given that the organisations chairman is a lecturer in social sciences with extensive research experience, and that he was able to access the assistance of two students to conduct the fieldwork, this was both economically and academically logical. The EMCDDA (ibid) also note that;

> *The obvious disadvantage of internal evaluators is their potential lack of objectivity due to both their dependence on the organisation and their personal relationships with the staff…. In any internal evaluation, some level of expert consultation is useful in order to avoid pitfalls and shortcomings*"

To guard against any conflict of interest and or overly subjective perspective a senior lecturer in the School of

Applied Social Studies, Dr. Cathal O'Connell, agreed to act as an independent external advisor.
From the outset this study has therefore been aware of the potential for such conflicts of interest to bias the methods, conduct and findings of the study and have guarded against this by constantly questioning the operation of this study and seeking the guidance of the external advisor.

Research Methodology

Following the discussions outlined above, an informal, preliminary interview was held with two key project staff by the principal researcher in late January 2010 to outline the parameters of the study and commence the research process. From this preliminary work the following research questions were formulated to act as anchoring points for the study;

Can community based drugs projects such as the GCDOP effectively deliver services across the range of the 'tier' system currently employed as a key delivery mechanism in Irish substance misuse interventions?

In using the this project as a heuristic case study the question can be reframed thus;

Does the Gurranabraher-Churchfield Drugs Outreach Project deliver services to persons located across the entire tier spectrum?

Flowing from these questions was the following set of aims;

1. The background context is to be explored in detail through a review of the pertinent literature sources in order to understand the host of factors that influence and impact on community based youth and drugs work interventions in contemporary Ireland.

2. The project is to be profiled in detail in order to uncover its structure, methods, theoretical approaches and models of work.

3. The project is to be evaluated on the basis of its (a) original aims and objectives, (b) the mission of the sponsoring agency, (c) the National Drugs Strategy, (d) the Local (Cork City) Drugs Strategy, (e) the National Youth Work Development Plan, and (f) the service user perspective. The EMCDDA evaluation guidelines are to be employed as a framework tool in this regard.

4. The feasibility of providing a comprehensive multi-level service to drugs users in the Gurranabraher/Churchfield area of Cork City based upon the existing project is to be explored.

5. The overall workings of the project are to be reconstructed in theoretical terms with the intention of publicising the project's model of work to interested parties (such as the Drugs Task Forces and various Youth Services) locally, nationally and internationally. This particular aim coincides with the research objectives of the (interim) National drugs Strategy 2009 – 2016.

The bulk of the fieldwork occurred in February 2010, when the research team located in the project's premises for the week Monday 22nd to Friday 26th in order to conduct interviews. The research team stayed on site for the week and were thus able to witness and record the inter-personal relationships, everyday events and rituals (such as 'tea-time'), and the numerous incidents that shape the project's operations, influence decisions and contribute to outcomes. The principal researcher had access to all available

documentation in the form of correspondence, internal documents, reports and diaries in the project.

This report is qualitative in nature and uses the Gurranabraher/Churchfield project as a case study agency. From a qualitative perspective reality is subjective, constructed, multiple and diverse (Sarantakos, 2005, p.41); the social world is experienced and interpreted differently by different people. The study is also inductive; the intention being to allow theoretical meanings to emerge from the social patterns, structures and facts that are uncovered and analysed during the research process.

The concepts and ideas of grounded theory guided the study. This theory invokes a sociological view of the world and the application of a set of accepted sociological concepts (Morse et al, 2009).

The empirical work was informed by what Everitt et al (1992) describe as a 'value base for practitioner research', a viewpoint that regards the value systems of the actors involved as being a key focus for understanding actions. The relationships that exist between actions and values are complex and multi-faceted, particularly in a professional setting, yet the nature of this relationship is fundamental to understanding the totality of this (or similar) projects ideology, principals, methods and activities.

Alongside the grounded theory approach the study incorporated the research principals from European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) series of evaluation manuals concerning preventative (Kroger, C., Winter, H., and Shaw, R., 1998), outreach

(EMCDDA, 2001), and treatment (EMCDDA, 2007) drugs work into the research methodology in order to achieve scientific consistency with best practice in this particular research field.

Qualitative methods were utilised in this study in order to investigate, analyse and theorise about this particular project in a meaningful manner. Such methodologies are eminently suitable for social research of the nature of this study and readily lend themselves to the adaptability and flexibility required to fulfil this study's aims;

> *"In qualitative approaches to evaluation, the aim is to understand a programme or particular aspects of it as a whole. Instead of entering the study with a pre-existing set of expectations for examining or measuring processes and outcomes (quantitative approach), the emphasis is on detailed description and in-depth understanding as it emerges from direct contact and experience with the programme and its participants"* (Kroger, C., Winter, H., and Shaw, R., 1998, p. 69).

Quantitative methodologies do not allow for such a full and detailed picture to emerge in such a micro-social system located within a singular geographical community setting. Rhodes, (in Greenwood and Robertson, 2000, p.24) makes the point that;

> "*While the dominant methodological approach in contemporary drugs research remains quantitative, there has been increasing*

> *receptivity to the use of qualitative methods as a means of understanding and responding to drug use*"

Qualitative methodology has become an integral component of research studies into drug use and related issues due in part to its ability to reach groups engaged in deviant and illegal activity, but also due to the depth of knowledge it can access from the population under investigation.

> *Qualitative research focuses on the meanings, perceptions, processes and contexts of the 'world of drugs' and offers ways of understanding drug use patterns and related responses. It can be an effective first step towards generating hypotheses or identifying issues that require more extensive and systematic data collection* (Hartnoll, in Greenwood and Robertson, 2000, p.15)

Notwithstanding the above starting position, the study did develop a tentative hypothesis; that the Gurranabraher project does offer an alternative approach to current drugs work operational procedures (the 'tier' system) and that it is eminently feasible to locate most if not all the required 'drugs' services within specific communities.

Data Collection

Primary data gathering was conducted through semi-structured interviews with selected expert respondents (staff and service users) from the project in question. The original intention was for the two student social workers to conduct interviews with the staff given the sensitivity of interviewing

service users. Within a few hours of commencing the fieldwork in the agency however the project worker, the manager and the principal researcher decided that both student researchers had displayed the necessary skills to interview the service users.

Additional information was informally gleaned from a range of well placed contacts in both the youth work and drugs work sectors; this information has proved especially useful in uncovering the 'mood on the ground' so to speak. It should be noted that quite a number of people who spoke to the research team in this regard wished to remain anonymous.

A brief empirical 'sub-survey' was conducted amongst random members of the public on site in Gurranabraher to gauge the public perception of drugs issues; this sub-survey took the form of an administered questionnaire. This particular research instrument was designed to be user-friendly in that the research team asked respondents a selection of questions in under two minutes. More talkative respondents were afforded the opportunity to flesh out their opinions.

This triangulation of information sources gives voice to different opinions and perspectives and offers the study a rich, informative and analytical data stream.

A selection of literature from relevant disciplines and fields of study in the shape of texts, articles, reports, policy documents and so forth was analysed and thereafter employed to provide a contextual foundation for the research and to inform the debates and arguments raised. This literature also served to highlight international practice and current opinion in the areas of youth and drugs praxis.

This material is arranged in a discursive format in the background context section of this report. This format was selected due to the nature of the topic, as Sadie Plant notes;

> "*There is no single explanation, no overriding rationale, and certainly no final solution to a drugs problem that cannot even be defined*" (1999, p.206).

Any attempt to make visible the complexities and contradictions that abound in this social realm requires due attention to a background of ideology, policies, theories, practices and a subjective set of realities.

Social reality is shaped by value systems and can never be perceived objectively; in rejecting the dominant positivist (and frequently quantitative) approach to evaluation Everitt et al (1992, p.126) put it that "*values are integral to evaluation; the very term contains the notion of value*". To properly understand the social world and the nature of social interventions we have to be aware that such interventions "*cannot be evaluated out of context*" (ibid). The activities under investigation cannot be isolated from the complex social webs in which they take place, nor can numbers and statistics relating to whether or not "*narrowly defined objectives have been met*" (ibid, p.130) be taken as objective truth. The approach to evaluating the work in Gurranabraher-Churchfield was therefore guided by the defining of practice evaluation as the following;

> "*Evaluation becomes concerned with making visible what goes on in practice....It is continually to question and problematise definitions of social*

> *need and established responses by social welfare agencies to that need. Further, it is to understand and make explicit the impact of economic and social policies and structures on the chances of practice moving in the direction of the good*"
> (Everitt et al, 1992, p.130)

The overall methodological approach can be summarised as "*self-evaluation in consultation with stakeholders"* (EMCDDA, 2001, p.9), "*a process whereby individual projects assess and reflect on their performance"* (ibid).

Chapter 2 The Background Context

The Drugs Task Force Projects

This report is concerned with the Youth Work Ireland Cork sponsored community drugs project in the Gurranabraher/Churchfield area of Cork City. Such community based drugs interventions, coordinated by the various Local and Regional Drugs Task Forces (LDTF/RDTF), began to come on stream in the late 1990s on foot of the Ministerial Task Force on Measures to Reduce the Demand for Drugs reports in 1996 and 1997. Originally there were twelve Task Forces in Dublin and one in Cork, a further Task Force was established in Bray, Co. Wicklow, in 1999, and the ten Regional Drugs Task Forces were established in 2001 (Pike, 2008, p.67).

The Drugs Task Forces' (DTF) operate under the aegis of the Department of Community, Rural and Gaeltacht Affairs. From a governance perspective, O' Mahoney notes that the;

> "*Local Drugs Task forces explicitly follow a social partnership model involving collaboration between the statutory, community an voluntary sectors, who all have representation on the Task Forces*" (2008, p.89).

The core rationale behind the local drugs task force project(s) was that locally based services were best equipped to respond to local needs and that a 'one size fits all[4]' approach

[4] The EMCDDA (2009) validate this stance of moving away from dogmatic responses and make this point explicitly, noting a shift "*from one size fits all towards a 'toolbox' of targeted measures*" (p. 12) across Europe. This can be perceived as a threat in certain quarters; strict adherents of the

could not possibly deal with the multiplicity of localised issues that affect communities in relation to drug use. These projects tended to be 'piggy backed' into communities with youth work service providers in particular being identified as viable delivery agents for a number of reasons;

- They already possessed hard infrastructural assets such as buildings and soft infrastructural assets such as local knowledge and a corps of volunteers in communities across the country.

- They were intimately familiar with drugs work among young people. Youth work had been operating in the drugs field long before the ministerial task force on drugs and had developed its own research and resources in the area[5]. Youth work agencies represented a profession with experience, ideas and resources developed locally, nationally and internationally.

- As a non-state intervention youth work possessed the required level of street legitimacy and trust amongst the target population. In many instances young people were interacting with the same organisations and workers recast in a new role.

Minnesota Model, for example, view any deviation from abstinence focussed programmes as futile (see Ffrench O' Carroll, 1997).

[5] For example, Cork Youth Federation undertook a survey of smoking, drinking and drug use among 2nd level school pupils in 1990; (see O'Fathaigh, 1990) whilst in 1996 the National Youth Health Programme produced a comprehensive pack for youth workers (National Youth Health Programme, 1996). Youth Work Ireland has just published a new and extensive Drug and Alcohol guidelines pack (see Bissett, 2010).

> Moreover, it is difficult to overstate the critical element that personal relationships play in effective work in this area.

With the above in mind, youth work agencies, alongside other community and voluntary initiatives, represented a rational and logical choice in terms of sponsoring agencies for these new projects. Youth service providers have been a key component of the Task Forces with organisations such as Foróige, YMCW, Ogra Chorcai and the member organisations of Youth Work Ireland (formerly the National Youth Federation) being key partners. The first Ministerial report noted that drug misuse was fast "*becoming a youth problem*" (1996, p.10) whereas the second report indicated that Ireland was dealing with a "*sophisticated and educated younger population*" (1997, p.45). The second report also recommended;

> "*the development of the youth services in disadvantaged areas*" and "*the development and implementation of a substance abuse prevention programme specifically for the non-formal education (youth work) sector*" (p.11).

These observations and recommendations copper-fastened both the centrality of young people's issues and of the actual and potential contribution of youthwork to addressing the use, misuse and abuse of psychoactive substances in Ireland. A specific resource stream, the Young People's facilities and Services Fund (YPFSF) was initiated in 1998 to assist youth organisations (amongst others, such as sports organisations) to provide services, programmes and amenities for young people deemed to be at risk of using drugs.

The background thinking behind the new projects was that each Drugs Task Force project would, in its own way, combat the growth of illegal drug use; assist those who were experiencing difficulties due to their use and benefit from the input of all the local actors (state, community and voluntary) in their own neighbourhood. Despite the tensions between the different constituencies inherent in partnership arrangements (Butler, in Pike, 2008) the various task forces have become a key feature in the Irish drugs ecology.

In keeping with this partnership ethos no dogmatic theory was imposed on these projects or indeed on the task force(s) themselves. On the one hand this allowed for a multiplicity of perspectives to be utilised but on the other hand it perhaps allowed for a disjointed and sometimes fragmentary development of praxis across different Task Forces and projects. The Horwath Consulting Ireland/Matrix Knowledge Group's evaluation of interim funded projects (2008A and 2008B) infers that the overall confusing and sometimes conflicting approaches adapted in different projects as being (potentially) problematic.

An alternative interpretation is that these multiple approaches dovetail with the objectives of the first (2001 – 2008) and the current (2009 – 2016) National Drugs Strategies in allowing for responses to be mutually supportive by offering differing services that target differing needs as perceived at the local level. From this vantage point the diversity of approaches is a major strength of the DTF projects. Moreover, this would coincide with international thinking on best practice and progressive policy (see EMCDDA, 2009).

The Regional and Local Drugs Task Forces have developed over the years and now represent an established feature in the Irish drugs ecology. They have also been successful at many levels in contributing to drugs policy and practice and crucially, they offer an opportunity for local people who reside in problematic drug communities an avenue of participation. In 2006 the Department of Community, Rural and Gaeltacht Affairs commissioned Goodbody Economic Consultants to review the Local Drugs Task Forces, the Comptroller general has noted that;

> *"The evaluation concluded that the local drugs task force programme had been very effective because a large number of measures relevant to the objectives set in the National Drugs Strategy had been implemented to address the drug problem at the local level. There was also evidence of higher levels of trust emerging between local communities and the statutory agencies concerned with drug abuse and this was attributed to the communication and mediation role of the local drugs task forces"* (Comptroller and Auditor General, 2009, p.79).

Despite the wide field of views that now input into policy and practice the danger remains that commonsense assumptions that see recreational illegal drug use as a social menace that must be eradicated continue to influence and indeed dominate the discourse. Allied to this legal-deviance perspective is the dominance of a medical model in research and treatment (Pike, 2008, p.44), resulting in the individualising of drugs issues; the social context is ignored as

the pathology and deviance of the individual problem drug user are presumed to be the issues that require attention.

Differing Perspectives on Drugs and Drugs Policies

The use of recreational drugs, the issues that stem from this use and the potential or actual responses that can be adopted represent a contested and diverse discourse with a plethora of different ideological, praxis and policy viewpoints. These diverse viewpoints manifest themselves visibly as a variety of activities that run the full gamut of psychoactive substance work; from prayer groups[6] to injecting rooms. As each form of intervention operates with its own philosophy, methods and praxis it presents drug users of all sorts with a menu of services; however, the menu may well consist of what is available locally, which may or may not meet the requirements of the)potential) service user. Sometimes the greatest challenge is to match the service user with the appropriate service provider; bearing in mind factors such as culture, age, gender, social class and geography.

This multitudinous panoply of policies, theories, approaches and interventions may not be such a negative development in an Irish context, as Maycock and Butler (2005) have pointed out. The flexible and multitudinous variety of approaches that have developed since the instigation of DTF projects has allowed approaches from the harm reduction

[6] The 'Victory Outreach Cork' group, a Christian 'anti-drugs' organisation, has held prayer meeting festivals in the parochial hall in Gurranabraher on Sunday mornings. They claim *"three essential values (1) a commitment to Christ, (2) Restoration of the family and (3) a positive work ethic".*

paradigm that are politically (and for some, morally[7]) difficult to accept have by now become well established. Despite the tentative acceptance of harm reduction ideas movement can be difficult politically; Kiely and Egan (2000) noted a "*climate of silence*" around harm reduction interventions and a discomfort amongst youth orientated drugs practitioners to discuss their work. Randall's exploration of the influence of research into drugs policy concluded that;

> *"Policy makers reach decisions which reflect compromise between what research recommends as the optimal course of action and what is most acceptable to public opinion or to the other key players in the broader policy arena"* (2008, p.ii).

Tensions are evident as support for harm reduction is interpreted by some as support for drug use or the thin end of a decriminalisation and legalisation wedge. From such a standpoint prohibitionist and abstinence models (manifested as a zero tolerance approach) represent the only routes to be followed (see EURAD at http://www.eurad.net/).

A degree of ambiguity therefore exists as agencies engage in a wide variety of harm reduction activities whilst publically maintaining an abstinence orientation. Arbour House, the central addiction treatment response agency in Cork city, has operated a methadone clinic since 2008 and a dedicated set of youth (under 18) and young adult (18 to 25) programmes (Irish Medical Times, March 2009).

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[7] For example, EURAD, 'Europe Against Drugs', an 'anti-drug' organisation, argue the harm reduction promotes drug abuse; see http://www.eurad.net/.

Reinarnman (2004) argues that this policy (and implicitly practice) ambiguity is both the result of ideological differences and a functional vehicle for effecting changes in policies and practices. From an Irish perspective this ambiguity is helpful in providing appropriate services without generating populist hysteria (Butler and Maycock, 2005) especially when it is considered that drug users are viewed as an immoral and deviant subset of the population.

The other side of this coin is that in the absence of rigorous and informed debate the general public continue to perceive drug use as a disease, categorise drug users as pariahs (McGreil, 1996) and as addicts, and hold a generally mis-informed opinion of drug issues[i]. The very ambiguity that has allowed services to develop also prevents them from entering into the mainstream of Irish political debate and requires ingenuity and creativity in further developing services.

An example of getting around this political complexity comes from the Cork Local Drugs Task Force, which in July 2001 defined its approach as "*harm reduction leading to abstinence where appropriate*" (Cork Local Drugs Task Force, 2001), thereby keeping onside with all potential critics. The de facto emergence of alternative strands in Ireland mirrors international developments; in a recent (April 2010) press release acknowledging harm reduction's "*move to the mainstream*" the EMCDDA noted that;

> "*since the mid 1980s, harm reduction has transformed from a peer-driven, grassroots approach to an accepted part of the European*

> *drug policy landscape*" and that "*today it stands alongside prevention, treatment, social rehabilitation and supply reduction as part of the 'comprehensive approach' to drug policy endorsed by the European Union*" (EMCDDA, 2010).

The overall approach that becomes evident from our investigation into the Gurranabraher-Churchfield project is a comprehensive one; the project does not limit itself to the tiered system (see below) and indeed rejects the labelling and categorisation implied by dogmatic adherence to such systems as being simplistic, narrow, abstinence orientated and indeed dismissive of drugs work that does not ultimately involve treatment.

Young People and Drug Use

The youth work foundation of this project blended with drugs specific ideas on praxis results in a social rather than a medical or legal perspective being employed as the primary focus. This characteristic is (again) consistent with developing ideas on good practice internationally (see EMCDDA, 2009). The rhetorical call for a holistic approach to be championed is common in drugs work and social interventions. Interventions such as the GCDOP have been operating from a genuinely holistic perspective since their inception. In marginalised communities it is people who suffer from cumulative disadvantages that comprise the overwhelming majority of service users (O' Mahoney, 2008, p.112). In this regard, they require responses that address multiple areas of their lives, not just drug use. A person such as this who quits psychoactive substance use will still have multiple issues to resolve in their life (Barber, 2002). Alexander (2001/2010)

categorises this as ‘psychosocial dislocation’; in essence people persistently engage in dysfunctional and self-destructive behaviours in an attempt to cope with the stresses and strains inherent in free-market driven post-modern and post-industrial society.

In relation to marginalised young people Steiker points out that;

> *“Interventions which are not restricted to addressing drug use alone have proven to be more effective, because they also address relevant needs that are connected to drug use”* (Steiker, in EMCDDA, 2008, p. 13).

Alongside this ‘sharp end’ of the work there exists a whole ‘continuum of use’ and in each community a local drugs ‘ecology’ (Edwards, 2005). In-depth knowledge of this local ecology is fundamental to quality early intervention and community based services are perhaps the only professional practitioners with meaningful access to this ecology. Their work brings them into contact with users across the drug-use continuum, from experimenters to ‘hardened’ addicts. They are also familiar with the families, the economic aspects of the local drugs trade (such as the dealer network) and with the (potential) next generation of users. In this regard the value of work conducted with those categorised as non-problematic users and especially young people who are in an experimental stage of drugs use cannot be under-estimated as these interventions can fundamentally alter young people’s use trajectories in many ways, from ‘risky’ to ‘safer’ use of substances (Leahy, in Hermann, 2008).

Haase and Pratschke's research (2010) showed that *"living in a drugs task force area has a measurable, statistically significant positive effect on drug use among early school leavers"* (Corrigan, in Haase and Pratschke, 2010, p.8), illustrating the effectiveness of youth/drugs work in altering trajectories. Coles (1995) regards locality as holding an importance equal to social class, gender and ethnicity in dictating young people's transitional trajectories and ultimate social destinations, highlighting the critical role that the neighbourhood plays in a young person's life. A neighbourhood that features a low age of introduction to substance use as a social norm heightens the risk of problematic use in later life; Von Sydow et al (in EMCDDA, 2009A, p. 8) report that;

> "*Early initiation during adolescence has been associated with higher probability of drug use later in life and greater difficulties in reducing or ceasing drug use*".

Moreover, across Europe it appears that;

> "*school students who reported binge drinking or smoking cigarettes were around twice as likely to smoke cannabis as students in the general school population*" (EMCDDA, 2009A, p.11).

The consequential requirement for quality youth work with a drugs focus with vulnerable groups is overwhelming, and indeed many organisations and agencies are engaged in such work across Ireland and Europe. Much of this work goes unrecorded however; indeed youth work's historical aversion to formalised and intellectualised practice hampers often its

ability to argue its case in this regard (O'Donovan, in Burgess and Hermann, 2010).

This form of drugs work demands both generic (youth work) and specific (psychoactive) sets of knowledge and skills (Gilman, 1992) and is by no means 'low-level'. The Europe Union's 'Drug Strategy 2005-2012' (2004) emphasises the importance of this form of youth related drugs work, stating that;

> "*Improving access to and effectiveness of prevention programmes and raising awareness about the risk of the use of psychoactive substances and related consequences. To these ends, preventative measures should include early risk factors, detection, targeted prevention and family-community-based prevention*" (25.1),

Furthermore, it argues for;

> "*Improving access to early intervention programmes (measures) especially for young people with experimental use of psychoactive substances*" (25.2).

Historically, drug use has always been associated with the young and intertwined with youth culture. A failure to engage with young people in an area as fundamentally important as the recreational use of psychoactive substances (see Davenport-Hines, 2002, Rudgley, 1993) is potentially catastrophic in terms of the reproduction of societal norms and values (Furlong and Cartmell, 2007) across generations. This reproduction of social norms takes place through

socialisation, a process that Newcombe (in O'Grady, 2001, p. 408) describes as;

> *"The process through which children acquire the behaviour, skills, motives, values, beliefs and standards that are characteristic, appropriate and desirable in their culture".*

Youth work and youth policies at all levels have been deeply concerned with the socialisation of young people (Leahy, 2010); this concern most obviously extends to concerns about young people's engagement with drug use, an activity that policy has been concerned with controlling, reducing and eliminating from the repertoire of socially accepted behaviours regardless of the cultural (or sub-cultural) milieu.

Ireland's Policy Response

Ireland's current policy response to drugs issues is guided by the National Drugs Strategy (interim) 2009-2016 which has two broad areas; (1) supply reduction, and (2), demand reduction, split into 5 'pillars';

- Reduction in the supply of drugs,
- Prevention of drug use (including education and awareness),
- Drug treatment (including risk reduction),
- Research
- Rehabilitation.
  (National Drugs Strategy, 2009-2016)

The Gurranabraher/Churchfield project straddles across the prevention and treatment pillars although it was deemed a Treatment project in the National Drugs Strategy Team

evaluation of LDTF funded projects in 2008 (Horwath Consulting Ireland/Matrix Knowledge Group, 2008B).

Drug services in Ireland are moving towards a tier system best summarised as follows;

> *"Four tiers of service delivery are used to denote different levels of service provision.*
> *These are:*
>
> ***Tier 1**: Generic services which would include drug -related information and advice, screening and referral and would be aimed at those who might consider, or who are at the early stages of, experimentation with drugs or alcohol. Service providers might include An Garda Síochána, General Practitioners or community and family.*
>
> ***Tier 2**: Services with specialist expertise in either mental health or addiction, such as juvenile liaison officers, local drugs task forces, home-school liaison, Youthreach, General Practitioners specialising in addiction and drug treatment centres. The types of service delivered at this level would include drug- related prevention, brief intervention, counselling and harm reduction and would be suitable for those encountering problems as a result of drug or alcohol use. Tier 2 interventions are delivered through outreach, primary care, pharmacies, emergency departments, liver units, antenatal clinics or in social care, education or criminal*

settings (An Garda Síochána, the Probation Service, the Courts Service, Irish Prison Service).

***Tier 3**: Services with specialist expertise in both mental health and addiction. These services would have the capacity to deliver comprehensive treatments through a multi-disciplinary team. Such a team would provide medical treatment for addiction psychiatric treatment, outreach, psychological assessment and interventions, and family therapy. Tier 3 interventions are mainly delivered in specialised structured community addiction services but can also be sited in primary care settings such as level 1 and 2 GPs, pharmacies, prisons and probation services.*

***Tier 4**: Services with specialist expertise in both mental health and addiction and the capacity to deliver a brief, but very intensive, intervention through an inpatient or day hospital. These types of service would be suitable for those encountering severe problems as a result of drugs or alcohol"* (ibid).

The Gurranabraher project is located in tier 3; identified in the 2005 'under 18's' report (Department of Health and Children, 2005, p.5) as the tier most in need of additional development. In practice, the project does not implement a strict interpretation of tier system in terms of separating drugs work into a specific medically orientated activity and instead deliver service across these tiers, from the

experimental user to those who are encountering severe problems.

Fundamental ideological differences exist and inform in the manner in which societies, including Ireland, perceive drugs and drug users (O' Mahoney, 2008, Murphy, 1996). These differences may not be readily visible yet they can and do impact dramatically on the shape and nature of services.

From a critical discourse perspective it is interesting to note the absence of any mention of youthwork in the tier system. One can only assume that if youthwork received even a cursory mention it would be most likely be in tier 1, or at best tier 2. The placement of (generic) youth services in the lower tiers (under the umbrella of community perhaps) implies a lack expertise in dealing with drug issues (issues which are often only a part of the difficulties and challenges facing young people) and the claiming of expertise by those higher up the tier system. In many instances properly resourced youth facilities can and do assist young people in resolving drug issues before they escalate into serious problematic use. The tier system places value on knowledge in the addiction and mental health realms and relegate other equally valid perspectives to a subordinate position in a hierarchy of expertise and power.

Likewise, the use of the term 'addiction[ii]' (a heavily contested term; see Klein, 2008) at the pinnacle of the tier system implies a return to a 'one size fits all perspective' and a dismantling of any comprehensive services that currently exist. The Department of Health's (2005) 'under 18s report' is heavily slanted towards a rehabilitation-medicalised perspective that constructs drug use as a 'one way street'

that leads to addiction and in underpinned by mental health issues[8]. Again, the nature of the discourse betrays a medicalised ideology with phrases such as 'patient' implying a sick person that can be cured.

One cannot deny the importance of areas such as mental health and the addictive properties of (some) psychoactive substances, however, affording primacy to this particular construction of drug use misses the reality of functional and normative drug use by young people (Plant and Plant, 1992) in society; even if this drug use can on occasion become dysfunctional and impact adversely on the individual(s) concerned. In many instances the (young) person is not addicted but is engaged in risky or crisis induced behaviour (including drug misuse) and it is these areas that require attention.

Drugs, Inequality and Social Exclusion

The fundamental issue of social inequality enters the debate at this juncture; is it just a coincidence that across the globe those who suffer most from intoxicant related ills happen to be in the lowest of the socio-economic ladder in their respective society? Roberts (2010) point out that young people's problematic drug use is shaped by numerous factors not least of which is the community and social context in

[8] The Working Group's members appear to have been drawn predominantly from medical and civil service backgrounds with the youth services sole representatives coming from the management of an inner City Dublin DTF project. The group did not feature representation from any of the core youth work provider organisations. This is remarkable given that recommendation that (overall) services should be "*designed in such a way that young people would be encouraged into and retained in order to benefit from treatment and rehabilitation*" (2005, p.3).

which they live their lives. The EMCDDA acknowledge that amongst young people;

> *"Groups that are particularly vulnerable include young offenders, young people in institutional care, early school leavers and students with social or academic problems, and young people who live in disadvantaged families or neighbourhoods where multiple risk factors and problems associated with drug use are concentrated"*
> (EMCDDA, 2008, p. 9).

Briggs (2008, p.18) alerts us to the fact that "*social exclusion is often the experience of those who take fast track routes to adulthood*". Across Europe, the breakdown of what has been deemed the 'traditional transitional pathway' from education and into the labour market for the working class has collapsed; this collapse exposes young people, especially from the working class, to fragmented transitions that have lost the traditional working class milestones along the routes into adulthood. Consequently, these young people are exposed to new sets of challenges, difficulties and obstacles in their transitions unknown to their parents or others in their communities. Deficit orientated corrective measures (such as early school leaver training) can assist individuals to a degree yet the structural problems raised by free-market neo-liberal policies continue to undermine hitherto relatively concrete expectations of employment in industrial society (Walter et al, 2006). The net result is both material deprivation and a sundering from former ways of life as the new realities of unemployment, underemployment and/or precarious employment come to dominate the

neighbourhoods of the (formerly) working class. In tandem with the economic hardship comes a reorientation of the norms associated with industrial society as at least some of the population, particularly those on the cusp of adulthood, drift away the previously established routines and traditions of working class life in working class communities.
Baumann (2005) argues that the post-Fordist shift towards flexibility, outsourcing, downsizing and rationalization of industry has led to the "*cutting down of the volume of labour"* (p.41) and an enormous widening of the gap between rich and poor in the Western world. This in turn leads to a;

> *"Subjective sense of insufficiency with all the pain of stigma and humiliation which accompany that feeling is aggravated by a double pressure of decreasing living standards and increasing relative (comparative) deprivation, both reinforced rather than mitigated by economic growth in its present, deregulated, laissez-faire form"* (Baumann, 2005, p.41).

Alexander (2001) contends that drugs offer an escape from these unwelcome realities and/or a potential economic avenue of success within an individual's particular social context;

> "*Even the most harmful substitute lifestyles serve an adaptive function. For example, devoted loyalty to a violent youth gang, offensive as it may be to society and to the gang member's own values, is far more endurable than no identity at all*" (2001, p.4).

Being a drug gang member can bring both status and monetary reward and even a 'junkie' lifestyle allows an individual to form an identity of sorts and thus resolve the Eriksonian 'crises' of youth (Erikson, 1968). White (2010) found that amongst 'hardened' users in Dublin the need to belong to a community, even a dysfunctional 'junkie lifestyle' community, acted as a powerful disincentive to change as it would entail a parting from this community. Here we see a visible form of Durkheim's organic solidarity that defies the logic of a medicalization paradigm; the bonds of a community, no matter how (ultimately) destructive, hold a far greater attraction than the mechanical solidarity offered through therapy type groups. Relationships matter, sometimes beyond even health and well being as defined by those in society invested with the power to diagnose the fit from the sick.

Psychoactive substance use is a highly complex area shaped by all manner of forces and therefore a range of properly resourced measure are required to address different individuals in different situations. Nevertheless, even supposing a vast investment in services, it is difficult to envisage the disappearance of drug problems in modern society so long as gross social inequality remains. From this (social) standpoint psychoactive substance use is an outcome of deprivation, marginalisation and inequality that will persist until these injustices have been removed from society.

Chapter 3 Reponses, Interventions and Contemporary Issues.

Fear has been expressed from some quarters in youthwork (sources confidential) that the budget cuts resulting from the recent economic downturn allied with the championing of rehabilitation/residential treatment centre type interventions will see a downgrading of youth work led drug interventions.
In July 2009 it was reported that funding for the Drugs task Forces would be cut by 2 million euro; from an already lowered budget of 32 million (Irish Examiner, 30/7/09). In decrying these rumoured cutbacks Dr. Joe Barry from the North Inner City (Dublin) Local Drugs Task Force argued that the task forces were making a significant contribution to the maintenance of social cohesion despite "*decades of difficulties*" and that a lack of funding would see the re-emergence of problems in this area (ibid). By December 2009 38 drug projects had experienced funding cuts with 11 facing closure (Irish examiner, 18/12/09). In the same timeframe the state ramped up provision for top tier services through a grant of 900,000 euro to tackle the waiting lists for heroin treatment (Irish Examiner, 30/7/09).

By October 2009 1.1 million was being allocated for capital funding for additional treatment centres alongside the provision of extra counselling hours and detoxification beds to "*enable service providers to respond to the increased demand for addiction services*" in the HSE South region (Irish Medical Times, October 2009).

At this juncture we may postulate that the 'Research Outcome Study in Ireland Evaluating Drug Treatment

Effectiveness (the ‘ROSIE’ study, Comiskey et al, 2009) may be having an (unintended) adverse effect on policy making. According to the then Minister for State with responsibility for the national drugs strategy John Curran this study was;

> “*Commissioned to establish the current impact of methadone treatment on the health of individuals and on offending behaviour. The fact that over 8,700 people are now included in the methadone programme represents a significant achievement and illustrates the focus that the Government is putting on tackling the problem of drugs misuse. The outcome of this research shows that treatment does work. There were significant reductions in drug use after one year in treatment and those in treatment also reported that their involvement in crime had reduced very significantly*” (ibid.p.8).

ROSIE’s focus is on opiate drug users commencing new treatment; the study does evidence overall success in the outcomes for the sample group; however, it would be counter-productive for the state to apply the ‘treatment works’ learning from this study as a generic approach to substance use issues in society and a particularly negative development if the resources from community based holistic measures were to be redeployed into treatment.

The positive developments for treatment centres are offset somewhat by the scaling down of community based interventions. In the Mid-western Regional DTF for example several preventative-educational projects operated by Limerick Youth Services have recently (April 2010) been shut

down. The supposed rationale behind this closure is apparently grounded in a regional imbalance insofar as that North Tipperary has no Drugs Task Force projects whereas Limerick had a number of these interventions. The burgeoning primacy of treatment as the preferred policy option has also been advanced as a reason for this closure.

Whilst not wanting to deny resources to treatment centres the fear is that we are witnessing a de-facto realignment of resources away from the voluntary, community and youth sectors towards the medical service providers; this realignment is also ideological in that drug use is being constructed as a progression into addiction and reasserts medical primacy. From this perspective the function of the DTF projects is to serve as an engagement and referral vehicle into (medicalised) treatment or, alternatively, to occupy 'clients' who are on a waiting list until a place becomes available. This (heavily contested[9]) construction of problematic drug use presumes addiction as the outcome; the logical consequence of a progressive disease. Arguably, this leads to a strictly numerical evaluation of a project's effectiveness in that a high number of drug users referred into treatment equates with a high performing project.

Hitherto hidden tensions are also becoming apparent; the Cork Local Drugs Task Force's attempts to reach consensus on operational methods led to much disquiet as youth work services perceived their roles as being relegated to that of "*taxi drivers for the treatment centres*". Anecdotally, projects now appear to be adjudicated on by the numbers of

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[9] Thomas Szasz has produced perhaps the most devastating critique of the medicalised view in 'Our Right to Drugs; The Case for a Free Market', 1992.

‘clients’ they refer on up the tier system and into rehabilitation/treatment. There also exists a most definite feeling that the youth service contribution to the development of services in the community is being deliberately downplayed and portrayed as ineffective.

This is in contradiction to best practice internationally. The divestment of resources from lower tiers would represent a seismic step backwards in service provision in this area, a disassembly of the partnership ethos, and an undue concentration of power and influence in the medical-treatment approach. Such a development would also contradict the Government’s own policy response in the form of the 2009-2016 (interim) National Drugs Strategy, a strategy that recognises the complexities of the issues involved and the role of the voluntary sector in addressing these issues.

If these fears prove correct then the *de facto* downgrading of youth service interventions in the drugs realm in Ireland is a most troubling development. The tier system operates from a medicalised world view, and in so doing relegates the social analysis to a peripheral position when in actuality we would do well to consider the social world as the primary factor in drug use.

These fears are not groundless and reflect the contested nature of drugs work. In a 2005 submission to Strategic Taskforce on Alcohol the Faculty of Substance Misuse of the Irish College of Psychiatrists argued strongly for a 4 tier system, that tier 3 (treatment) facilities should be multidisciplinary and that *“a consultant addiction psychiatrist should lead the specialist multidisciplinary outpatient addiction team”* (2005, p.6). The submission constructed the

medical viewpoint as the primary perspective on drug misuse. Youth, community and voluntary interventions did not feature in this submission's second appendix on 'adolescent addiction treatment' but the tier 1 and 2 services where these forms of intervention occur were described as 'low intensity'. However, in reality, youth projects (not just youth drug projects) have been delivering services to young people over lengthy periods of time with severe drug issues and substantial other issues for many years.

The categorisation of preventative and educational work in the drugs field as lower-level can be interpreted as both disrespectful towards the professionalism of practitioners (both paid and voluntary) and a claim for primacy by the medically orientated interests in the drugs field. This state of affairs is not conducive to the further development of appropriate services founded on inter-disciplinary respect and egalitarianism. Indeed it serves to further marginalise the actual drug users, their families and their communities.

<u>Changes in the Irish Drugs Ecology</u>

Recent evidence does show possible signs of change in drug use amongst young people, perhaps heralding another change in the dugs ecology. Long and Mongan, (in Drugnet Ireland, Issue 33) note that figures from the European School Survey Project on Alcohol and other Drugs (ESPAD), the Health Behaviour in School-aged Children (HBSC) and the National Advisory Committee on Drugs (NACD) surveys show a decrease in alcohol use (but not drunkenness) and a fall in cannabis consumption amongst young people; they caution that although "*these figures could represent a genuine fall in the use of alcohol and cannabis*" they may also represent changes in the survey samples or the manner in which the

questionnaires were administrated. However, the NACD's 2008 survey (National Documentation Centre on Drug Use, 2008) showed that a marked increase in cannabis use amongst young adults[10] (from 26% in 2002/3 to 31.4% in 2006/7) and cocaine (from 4.7% to 8.2%).

Compiling accurate statistics in the area of drugs use is bedevilled by the illicit nature and moral opprobrium of substances use, and by the secretive manner in which a large element of the activity takes place. On the one hand statistics are useful to a point in generalising; on the other hand the contradictory messages from statistical surveys illustrate their limitations.

[10] The young adult category is from 15 to 34 years of age.

Chapter 4 Profile of the Gurranabraher-Churchfield Drugs Outreach Project

Area Profile

Gurranabraher and Churchfield are two neighbouring communities on the Northside of Cork City. Gurranabraher was built in the 1930s as social housing; Churchfield was built later (in the 1950s), again as a social housing intervention. Gurranabraher consists of five city wards whereas Churchfield is a separate ward. Historically, these two communities have suffered cumulative social disadvantage and issues such as unemployment, early school leaving, lone parenting and a high social welfare dependency rate feature strongly in the area.

Edwards and Linehan's research showed that within the city;

> *The majority of wards in the north of the city have the lowest proportions of people who fall into the "Higher professionals" socio-economic group, where no more than around two percent of people are "Higher professionals"* (200, p.46).

Moreover, in the key indicator areas of educational obtainment, unskilled labour and employment the Northside of the city fared poorly (ibid). Tellingly, even at the height of the 'Celtic Tiger' economic prosperity did not trickle into these communities;

> *"Despite the overall decline in unemployment, Cork has eleven of the State's eighty eight worst unemployment black-spots, which have average*

> *unemployment rates of25%. All of them are within the northern area of the city"* (ibid, p.47).

Despite these issues the area has a strong level of social solidarity and a solid working class community identity. This identity carries with it a high value on what might best be described as 'traditional working class morals', a commitment to family, community and perceived roles in society. Tovey and Share (2003) note that;

> "*class and inequality are often related to neighbourhood and community; territory, residence, distance, space and movement help to shape people's experiences of class, inequality and poverty*" (2003, p.181).

An overarching set of shared norms and values provide the social glue that binds the Gurranabraher-Churchfield geographical area into a community. However, these norms and values were forged in an industrial setting insofar as that these areas were traditionally (predominantly unskilled) working class, and not welfare dependant. Home ownership (facilitated through tenant purchase from the local authority) is common. In the 1980's the collapse of the city's industrial employment sector contributed to a rise in social deprivation. The 'fragmented transitional pathways' mentioned earlier have become established as secure employment becomes rarer and rarer for the unskilled young (and not so young) worker. Key markers of progression in working class life connected with employment have all but disappeared and with them the status and behavioural expectations. The term 'idle' remains in force on the Northside of Cork as a synonym for unemployment; this term

carries subtle undertones of laziness, unsuitability and weakness. Such a construction of unemployed young people feeds into a labelling process that further alienates young people who can see no particular reason to delay any opportunity for gratification (Levitas, 1998).

Despite the economic successes of the tiger era neighbourhoods like Gurranabraher and Churchfield did not catch up with more affluent communities and represent a near perfect breeding ground for drug use as an economic activity (for the dealer), as an escapist activity, and as an alienated youth population's transition into adulthood mechanism. The compound effect of intergenerational poverty allied with low expectations erodes the social glue as hitherto 'deviant' norms become established as acceptable behaviour by a significant (even though numerically small) sub group of the population.

Within the working class social milieu illicit substance use would still be considered deviant although a strong tolerance for alcohol use persists alongside an equally strong 'pioneer' ethos of total abstinence; indeed our brief administered questionnaire survey (see below) showed a desire for the legal age of alcohol consumption to be raised to 21.

Nationally, the Alcohol and Drug Research Unit (2008, p. 23) found that although heroin, cocaine and ecstasy were viewed as dangerous; *"only 12.7% perceived alcohol as posing a high risk, while 28.4% deemed tobacco and 30.1% deemed cannabis as posing a high risk"*. This illustrates the acceptance of alcohol in Irish society and the lack of connection between of one of the biggest cause of death (tobacco) globally and an 'everyday' legal substance.

The sub-survey conducted amongst random members of the public found that the overwhelming majority of respondents perceived the area to have a ‘drugs problem’, agreed with the banning of substances that are currently illegal, wanted ‘head shops’ banned, had witnessed illicit drug use in the area, personally knew drug users, and supported the criminalisation of dealers at virtually all levels. Attitudes softened somewhat towards users with some agreeing that they should be viewed as victims and/or in rehabilitation. One comment was that the “*drug squad should deal with dealers*” and that “*judges (should) come down hard on them*”.

Both the SPY (Special Project for Youth) and DTF (Drugs task force) projects are viewed positively in the neighbourhood although some older people expressed concerns about the drug project’s service users. The project staff and local people perceive the area to have a high crime rate and an underlying fear of vigilantism is reported amongst the drug using population.

An apparent rise in the city crime rate has been attributed to the drug economy, particularly petty street crime to fund heroin use (Irish Examiner, 8/3/10). According to Chief Superintendent Michael Finn fully one-third of drug seizures in the first 11 months of 2009 were of diamorphine (heroin) with an estimated street value of approximately 537,000 euro (Irish Examiner, 1/12/09). The linkage between alcohol use and youth crime has been emphasised in a study conducted by the Irish Youth Justice Service with up to half of all such crime involving alcohol (Irish Times, 4/8/09).

Youth Work; Structure and Services in Gurranabraher-Churchfield.

The Cork Youth Federation (precursor organisation of Youth Work Ireland Cork) initiated a VEC funded special project for youth (SPY project) in the area in 1989. The project was managed by the Cork Youth Federation's regional director and had one full time worker, and a number (usually 2/3) of part time VEC tutors. This project was located within the parochial hall in Churchfield and was known locally as 'Youthlinks'. In 1994 the project's name was changed to 'The Gurranabraher Youth Development Centre'.

In 1997 the Cork Youth Federation ceased operations and the National Youth Federation (now Youth Work Ireland) took over the management of the SPY project. In 1998 YPFSF monies were secured to fund an arts programme (U4EA). The current director of services and SPY project coordinator were both appointed in 2000.

A local management board was formed in 2004, tasked with eventually taking responsibility for all Youth Work Ireland operations in Cork; Youth Work Ireland Cork became a full member youth service of Youth Work Ireland in May 2009 and the process culminated in January 2010 when a new company, Youth Work Ireland Cork, officially became responsible for all Youth Work Ireland[11] activities in the Cork region.

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[11] A number of different youth organisations provide services for young people in the Cork area.

The project changed premises a number of times before moving to its current location in March 2009. It now employs a number of staff in both full and part time posts to cater for the needs of young people in the Gurranabraher and Churchfield area. The DTF project commenced operations in 2001.

The Development of the Gurranabraher-Churchfield Drugs Outreach Project

The genesis of the Gurranabraher-Churchfield Drugs Outreach Project was an 'Integration Day' held in Gurranabraher-Churchfield on April 1st 2000. The purpose of this event was to bring together the various actors in the youth scene[12] in these neighbourhoods in order to better liaise and cooperate in service provision. A clear finding from a series of workshops and meetings held that day was around the lack of local intervention services for the issues connected with drug use and the need for this to be addressed. The consensus reached was that a Local Drugs Task Force community project represented the optimum response to achieve this end.

A further recommendation arising from this integration day was for the establishment of a 'youth network group'. This group subsequently compiled the application for a Local Drugs Task Force project in the area with the National Youth Federation taking the management role and now act as the Gurranabraher-Churchfield Drugs Outreach Project's

[12] Local young people were strongly represented amongst those present and actively participating that day, giving a firm indicator of the sponsoring agency and the wider youth network's commitment to the meaningful involvement of young people in their own affairs. Others present included parents, schools, Gardai, training agencies and community groups.

advisory/steering group (National Youth Federation and Gurranabraher Youth development Centre, 2001).

At this point in time (2000) the original Cork Local Drugs Task Force Projects had been evaluated by King (2001), with eleven of these projects being mainstreamed. The solid performance of the community based projects targeting young people at risk augured well for the expansion of this form of provision and indeed the Gurranabraher-Churchfield area was identified in the Cork Local Drugs Task Force 'Action Plan' (Cork Local Drugs Task Force, 2000) as a community requiring such provision.

The 1996 'Gamma Report' evidenced the locality as one of high disadvantage and therefore vulnerable to problematic drug issues; the six wards in the area had an early school leaving rate of over 50% (Gamma, 1996, in Gurranabraher-Churchfield Outreach Project Application Form to Cork Local Drugs Task Force, 2000). At the time, the rate for Cork City was 33.7% and the national level was 34.5%. Research has evidenced early school leaving as the precursor to life-long marginalisation and the primary indicator of young people getting into difficulty in Ireland (Burgess and Leahy, 2003, Leahy 2006); the statistics from the Gurranabraher-Churchfield area strongly indicated early school leaving and consequential marginalisation as contributory factors in problematic drug use amongst the area's youth population.

The Gurranabraher/Churchfield Outreach Project was thereafter initiated under 'Round 2', a second tranche of drugs task force projects, in 2001. The project was established to fulfil one core aim;

> “*To support existing youth initiatives and develop responses to the needs of young people from the area involved in or at risk of becoming involved with drugs*”
> (Collins/Cork Local Drugs Task Force, 2001).

The project received funding of £46,000 per annum; the current funding level is €66,016 per annum. The project had sanction to recruit one ‘community drugs worker’ (although the incumbent has always been known as the drugs worker or project worker) and a worker was recruited to this post in August 2001, the first work with young people commencing shortly thereafter.

A new project worker was appointed in September 2002. This practitioner had previously been employed by the SPY project in a number of capacities and has been working with Cork Youth Federation/Youth Work Ireland Cork in Gurranabraher/Churchfield since 1989. The Youth Work Ireland Cork services director is responsible for the direct managing of the GCDOP.

The project was recommended for mainstreaming[13] in 2009 following an evaluation by the Horwath Consulting Ireland/Matrix Knowledge Group (2008B) of interim projects in 2008.

The original focus of the DTF project was outreach drug education and prevention[14], with outreach work being characterised thus;

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[13] Mainstreaming is the process by which a project’s future funding is transferred to the relevant state agency.

[14] An example of such preventative work is the skaters group. Alongside the core drugs work the project was instrumental in the formation of the

> *"The outreach worker is the link person between drugs users and harm minimisation services. The assumption behind outreach work is that individuals are 'out there' using drugs and not in contact with existing harm minimisation or drug treatment services. These include young 'chaotic' drug users, homeless drug users and drug users involved in the sex industry"* (Drugnet, Issue 11, p.10).

Kori et al (1999, p.8) list the broad aims of such outreach work thus;

> *"Throughout the EU, four general aims of drug outreach work have been defined at national level:*
> *• to identify and contact hidden populations;*
> *• to refer members of these populations to existing care services;*
> *• to initiate activities aimed at prevention and demand reduction;*
> *and*
> *• to promote safer sex and safer drug use.*

They further comment on the youth work construction of outreach;

Cork Urban Skateboard Project (CUSP). In this case the project worked with young skateboarders towards the provision of skate parks in Ballincollig and in Cork City. A number of the then young people involved in CUSP maintained both their interest in skateboarding and their links with the project. Now in their early twenties, some of this group have recently opened an indoor, commercial skate park at Penrose Wharf.

“The Youth Work Model is the oldest in Europe; since the 1960s, youth workers have been actively seeking contact with 'problem youth'. Characteristically, their aim is to find solutions to young people's problems in their own environment, rather than deciding behind a desk what they consider is best for the person concerned. The goal is to prevent further marginalisation and encourage social integration” (ibid, p.10).

The GCDOP approach adheres to this construction of outreach work and whilst retaining the outreach element the project’s focus has changed and developed significantly over the intervening years. The project is now operating on a number of levels across the drugs issues range, this broadening of its mandate and activates is evident in its current orientation;

“*we went from being an education and information project and a diversion project very much into taking on direct work, treatment work and support work and family work so that’s been the main shift*” (DOD).

At the time of the project’s establishment the main psychoactive substances available and of concern in Cork were alcohol[15], prescribed medication, cannabis, ecstasy,

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[15] Interestingly, Cork was the only Local Drugs Task Force allowed to list alcohol as a drug at the time of the community based projects inception, highlighting the political necessity of addressing illegal (and especially heroin) drug use.

solvents, LSD and amphetamine. Cocaine had just begun to make serious inroads in Cork whilst heroin use was rare and sporadic (Drugs Unplugged, 1999). The availability and popularity of particular substances has waxed and waned over the intervening years; heroin and head shop merchandise have become increasingly available whilst alcohol remains the bedrock substance in polydrug activity and as a sole drug of use. Alcohol is often perceived as a 'non-drug' due to its legal status; however, this disguises the sheer potency of alcoholic drink. The EMCDDA state that;

> "*Intensive alcohol use is often a major but overlooked component of polydrug use. For example, stimulant drugs such as cocaine may enable users to consume large quantities of alcohol over longer periods than would otherwise be possible*" (EMCDDA, 2009A).

Project Profile

Location

A key development in the project's recent past was the opening of the new 'hut' on Gurranabraher Road as premises for the various YWIC projects; prior to this the project had been operating more or less on the street or at inappropriate venues. The ability to meet service users in a friendly, relaxed and welcoming space represents a welcome development for the project staff and service users.

The project is physically located within the 'new hut[16]' community centre on Gurranabraher road and has a dedicated office within this building. The office is small and inadequate for the project's needs.

It is also located within the overall space of Youth Work Ireland Cork's premises on the top floor of the new hut which is inappropriate at times given the volume of traffic (particularly young people and children) in the building and the desirability of confidentiality. In the words of the Project's manager "*the only difficulty we would have is that because it is known that people who have difficulties with drugs come there, sometimes we are just conscious that they'd be known locally in the area*" (DOD).
This issue is partially offset by the use of the backstairs emergency exit as an access route. Conversely, the location allows for staff support from other YWIC personnel and allows access to the resources in the YWIC premises and in the main hall downstairs.

The physical location is an asset insofar as that it is highly visible. Through the long-standing involvement of Youth Work Ireland Cork in the community a solid degree of trust has been built up over the years by the organisation and the individual workers. Potential service users can make contact on the street or in the building itself. The high traffic volume can therefore also serve as camouflage for potential service users who are nervous, anxious or embarrassed to be seen accessing drugs services. The lack of a physical space in

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[16] The original hut had fallen into disrepair; YWIC were instrumental in securing funding for a new 'state of the art' community building. Although the City Council refer to the building as the 'Community Resource Centre' the 'hut' is used of the local people.

Churchfield is a deficit in easy access for potential service users.
The atmosphere in the project is positive, welcoming and relaxed without being cloying or overpowering; the service users reported it as *"friendly and non-intimidating"* (SM).

Project Structure

The project is structured in a non-hierarchical manner and is organised around individual tasks allocated to the various workers. Overall responsibility rests with the director of services who in turn reports to the directors' board of Youth Work Ireland Cork. However, on a day to day basis the project's personnel have a high degree of autonomy to make the necessary decisions and are free to operate as they see fit. A local advisory group, the 'Youth Network' sits parallel to this operational structure.

This Youth Network was the original applicant body for a LDTF project in the area and consists of various actors with a stake in the youth sector in Gurranabraher–Churchfield.

Their current and ongoing role in relation to the LDTF project is to act as an independent input into the strategic decision making of the project at management level, offer effective inter-agency liaison in the routine operation of the project, to present the project with the various agencies perspectives on youth and drugs issues in the locality, guard against the duplication and overlapping of work between the concerned organisations, and to offer support and advice in the running of the project (Collins/Cork Local Drugs task Force, 2001). They meet regularly and represent agencies such as

Emerald[17], Cork City Partnership, local schools, An Garda, and the local community development project.

These arrangements reflect the organisational ethos of the sponsoring agency (YWIC). A high value is placed on the actual workers insofar as that the sponsoring agency operates a reflexive action model of praxis in its work. This particular approach demands high calibre personnel who are willing and able to operate both independently and as part of a team.

The project's structure is ultra-flexible and the operations of the project can be re-orientated quickly and effectively; this is a positive feature of small organisations (or sub-sections of larger organisations).

Management and Support

The director of services has overall responsibility for the project and reports to the Board of Directors of Youth Work Ireland Cork. There are seven directors at present, some of whom live in the Gurranabraher area. A number of the directors possess qualifications in the areas of youth and community work. The director of services also provides praxis supervision to the staff on a regular basis; the provision of adequate supervision has long been recognised as a vital precursor for effective practice in the social field (Coulshed and Orme, 1998, Seden, 1999). The staff reported excellent relations with the board and confidence in the management, whom they described as very supportive. All workers avail of supervision and the project has direct

[17] 'Emerald' is a training facility for young women in a community setting; in order to maintain agency confidentiality we have not used the project's true title.

representation at board level through the project's semi-voluntary second worker[18].

Personnel

The key personnel are the two project workers; additionally, a number of people have made their services available on a voluntary or low-cost basis[19] including two counsellors. The principal worker was originally the woodwork tutor in the SPY project; he has since acquired qualifications in addiction counselling. Additionally, his interests in outdoor pursuits have proved beneficial in developing the project's programme. The semi-voluntary worker possesses guidance and counselling qualifications and has been with the project for over four years. She is currently nearing the completion of a degree level in social care; moreover, she resides in Gurranabraher and is therefore very much aware of developments in the community. The project manager-YWIC director of services has been professionally involved in youth work for over twenty-six years. He is qualified as a social worker and possesses a master's degree in social science specialising in the area of reflexive practice. He has also completed a higher diploma in child protection.

The project's workforce is ethnically white and Irish, and is drawn from a working class background. These characteristics have allowed the workers to deploy a wide

[18] The second worker was a voting member of the board of directors, however, when she switched from an exclusively voluntary role she was legally required to relinquish her voting right as a board member. YWIC are confident that when the 2011 Charities Act comes into force she will resume her former position on the board.

[19] One counsellor provides his services voluntarily whereas the second counsellor has offered the project 50 provides counselling time on an expenses only basis.

range of appropriate and sophisticated communications techniques in their work. The service users reported a high degree of security, trust and comfort with the workers and our observations of interaction between workers and service users showed a strong rapport underpinned by local language, humour and genuine warmth.

Project Vision

The staff group perceive the project's purpose as being the provision of as comprehensive a service as is feasible for (primarily young) drug users and those at risk of or from drug use in the Gurranabraher/Churchfield area, with the foci being support and education. Underpinning this aim is the aspiration to "*help people reach their full potential*" (POC). Service users identified the project's aim as offering assistance and providing security for people who need help. A strong degree of pragmatism was also evident in the staff's perspectives on the project; they readily identified what was achievable and what was (at this juncture) aspirational.

Alongside the grand vision the staff group identified a number of service gaps that require attention if such an all-encompassing service is to be achieved; detoxification facilities and the need for more staff in the project were the two areas that were highlighted in this regard.

Service Users

Note; statistical information regarding service users (January to October 2010) is provided in appendix 7.

The majority of the service users are drawn from the local community; however a small number of people come from outside the area. This is a trait in drug interventions and is connected with the potential or actual service user's desire

to remain anonymous. The service user group encompasses a wide range of drug related issues; in terms of substance use per se it ranges from minor experimental use (usually teenagers) to hardened and prolonged polydrug use. Such service users are frequently beset by all manner of additional social, familial, legal, mental health and economic issues (one individual is currently on remand for murder, several have over-dosed and a number have threatened/committed suicide). The severity of the issues affecting some of the group cannot be overstated.

Socio-Economic Background

The service user population are virtually all from the lower socio-economic strata of Irish society and have typically left school early (or if below age 16 are still in school), possess little or no formal qualification, and are unemployed. Some have precarious housing situations; others live in local authority housing. A feature of housing in the area is the lack of private rented accommodation; the bulk of housing is either local authority or owner-occupied. This in turn leads to a phenomenon whereby young adults move into bedsit-type private rented accommodation in areas such as St. Luke's/Wellington Road (Cork City's traditional flatland) yet to a large degree live in Gurranabraher-Churchfield. People's social networks, family homes and public space are still located in Gurranabraher-Churchfield.

Approximately 90% of chaotic drug users in the project are faced with legal charges or have charges pending (usually for acquisitive crime). Others (typically the younger ones) have been served with ASBOs and/or cautions from An Gardai and are on the Garda Juvenile Officer scheme. The chaotic service

users' social systems tend to be haphazard and harmful whist family relationships can be dysfunctional and strained.

Demographic Profile

The service user age range stretches from 13/14 up to mid-forties; the younger ones are typically in the experimental category and the work focus is around education whereas the older ones tend to be either long term chronic drug users or concerned family members who utilise the project for support, advice and assistance. The older age profile of some service users is in stark contrast to Jackson's report from 1997, in which he pointed out that (at that time) "*recent and current are highest at younger age and fall to almost nil over 35 years*" (p.6). This evidences the emergence of a far more hardcore of drug users and drug addicts in the intervening years; Cork city has effectively 'caught up' with other urban areas in having such a drug using population. In this respect the EMCDDA report that across Europe we are witnessing an ageing of heroin addicts and this situation will present new challenges in policy and practice (Drugnet Europe, Issue 72).

Some service users, although barely out of their teens have children of their own; a key motivating factor for them to effect change (in some instances) is the return of their children from care.

Despite the emergence of the older user a significant proportion of service users are in young adulthood; we may postulate that the drug usage of these young people has developed in a manner that is problematic in comparison to their peer groupings. As the vast majority of service users self-refer we may also advance the notion that these young people have recognised the problematic elements of their drug use themselves.

Health Status

General health is typically satisfactory for the younger service users; the heroin users tend to be in poor physical condition. Sexual health is a concern for the younger ones.

Service users reported mixed experiences of other services; a key issue was pre-conditions for accessing services and the length of time that one would be waiting for treatment. One respondent (Michelle) informed us that she had “*been 10 years trying to get clean elsewhere and achieved it in 10 weeks here*”.

Substances Used

The range of substances used is dynamic and dependant on factors such as price, availability, desirability and reputed effect. Within these parameters the main substances that the project workers come across are alcohol, cannabis (and its derivatives), MDMA, prescription drugs, cocaine and heroin. Head shop products gained a phenomenal albeit temporary slot in the market, a development attributed by the staff to price, availability and perceived safety. The introduction of a ban on headshops seems to have resulted in prior users to return to their old drugs and casual users to more or less forego these substances and their illegal alternatives. In this regard the EMCDDA report that a record number of new (synthetic) drugs entered the European drugs ecology in 2009 (Drugnet, April-June 2010) and the Irish Examiner reported that head shop drugs are mutating faster in order to avoid prohibition (26/7/10). It remains the case that such products can be accessed via the internet; the staff view is that the typical Gurranabraher-Churchfield young person will not be bothered with such a delayed gratification and will instead purchase cans (alcohol), cannabis or tablets of one sort or another.

Polydrug use is the norm rather than the exception with prescribed drugs featuring strongly; “*often, if people are presenting with something else, prescription drugs are often underlying*” (TS). Prescription drugs are perceived as relatively easy to access by service users and staff alike, with a robust illicit trade in such medication flourishing in the area.

The proliferation of head shops and the recent consolidation of heroin (Leahy, in Irish Youth Work Scene, 2009) in the local drugs ecology illustrate the ever changing nature of drug issues in one respect; an alternative view is that it is only the substances used that are subject to change due to availability, fashion and whim; the underlying social conditions conducive to drug problems remain and will remain for the foreseeable future. Edwards (2004) notes that;

> *“Cannabis and ecstasy use are found throughout the social-advantage spectrum. It is when the focus turns to heavy, dependant, harmful use that deprivation is seen most clearly”* (p.270).

<u>Service User Intake</u>

The usual means by which service users become aware of the project is through word of mouth from one service user to another; “*within the drug using community there would be communication-somebody will say to somebody else whom is using*” (DOD). Alongside this route the SPY project’s longstanding presence in the area is a resource for the local youth population in that local young people (and parents) seek advice and assistance from individual workers who direct such enquiries to the project staff. Familial referrals

are common; *"mainly mothers referring children and now, children being anything up to forty in some instances where somebody is living at home"* (DOD).

The staff's high local profile also leads to informal contacts being made on the street or outside the building. The importance of this informality cannot be overstated as it represents a safe entry to the project.
Outside agencies such as An Gardai, the HSE social work department and sometimes GPs refer also individuals to the project.

One interviewee reported that she found a flyer in the St. Vincent de Paul shop in Gerald Griffin Street and dialled the number. She further stated that the project met her immediately, in contrast to her prior experiences with services; i.e. Arbour house told her she would have to wait six weeks. The immediacy of response is important to note in this instance; given the (oftentimes) chaotic lifestyle of people with severe drug issues a person may well decide to seek assistance on the spur of the moment and feel rebuffed if services cannot (for whatever reason) respond. The project workers willingness and ability to react swiftly enables a first contact to take place. Even if the person decides to go no further at this juncture they will have met a worker and be aware of the service (this can itself begin the process of reflection in the person; especially if they are in a contemplative or even pre-contemplative stage, see Barber, 2002, p.40).

<u>Service User Expectations</u>
From the workers perspective the expectations of service users upon entry into the project can vary; however

unrealistic expectations exist with one worker stating that "*many wanting to get clean without seeing the whole picture, their coping skills may be low and even if they get clean they may not be able to maintain it*" (POC). Another worker commented that (they want) "*to be fixed immediately*" (JL). Parental expectations can be (unrealistically) high in terms of investing the project with quasi-mystical powers to effect change in their offspring's drug use. Some of the young people (particularly those referred in by An Gardai) don't possess any expectations insofar as that they perceive the project (on first engagement) as a semi-coercive attempt to make them conform, a possible last chance to change trajectory or a soft option in relation to the criminal justice sanctions they may be facing.

Some felt that they didn't know what to expect themselves, only that they "*wanted to vent, needed to start somewhere"* and were "*in too deep*" (SM).
Regardless of the access route taken by the individual participation in the project is entirely voluntary on the service users behalf; this is a strict criteria and in keeping with both the core ethos of the sponsoring agency and the basic tenets of best practice in the field of youth work.

Assessment
New service users are assessed through a conversational interview and a referral form from Arbour house; this particular document serves as an assessment tool as it can generate a wealth of information and assist in locating an individual on the 'cycle of change'. Thereafter, the staff team decides who is best suited to act as the lead worker with this individual. Factors such as age, gender and personal circumstances dictate the response. Usually (but not always)

the division is gender specific with the male worker dealing with the males whilst the female worker takes responsibility for the females.

Having both male and female workers is a strong asset for the project as the service users tend to be more comfortable discussing intimate and personal life situations with a gender specific worker. Our empirical research revealed that although not articulated by the respondents, assessment is in fact founded on the five core areas of social policy, health, housing, education, income and personal social situations.

<u>The Theoretical Basis of the Project</u>

The project's theoretical framework can be usefully divided into four overlapping and complimentary areas;

1. Inter-personal relationships with service users (including family work)
2. Drugs work
3. Youth work
4. Community work

The workforce display a strong grounding in various and complimentary theoretical notions across all four of these areas.

Interpersonal work is strongly informed by humanist ideas (Carl Rogers/Abraham Maslow/Carl Jung); these theories featured strongly as a baseline position with compassion, non-judgemental, empathy and positive regard being readily evident from observation of the interactions between the workers and the service users. The 'cycle of change' (Prochaska and DiClemente, 1984) model is utilised as an

assessment and working tool and ecological systems theory is evident in the project's interventions through family and community work. The family work undertaken is strongly informed by the 'Strengthening Families' programme (see http://www.strengtheningfamiliesprogram.org/.), with the project worker having completed training in this programme.

The project's overall theoretical approach in relation to drugs work is located in harm reduction (see Inciardi and Harrison, 2000); i.e. service users may not be willing or able to abstain from using particular substances, therefore the project should make every effort to assist such people in improving their life situations. This approach is wider than a strictly abstinence orientation and allows for incremental progress to be made; it also facilitates the prioritisation of areas other than drugs use as the focus of intervention (a systems approach). In this respect Rhodes and Hedrich's description of a 'harm reduction combination intervention' accurately describes the Gurranabraher-Churchfield project;

> "*A package of interventions tailored to suit local setting and need, including access to drug treatment*" (2010, p.22).

The harm reduction value base is also visible in the preventative/educational work of the project whereby every effort is made to deliver accurate and factual information rather than attempting to scare young people through the use of (usually counterproductive) lurid stories and harrowing survivor commentaries. The preventative work is grounded in a 'Risk and Protective' factors model in conjunction with community resilience (ibid, p.24). The EMCDDA (2005, p.19) has reported that harm reduction

interventions, despite initial (and usually mis-informed) local resistance, are often effective responses to drug public nuisance as an ancillary benefit to the core work.

Buhler and Kroger (2008) argue that (preventative) drug interventions can benefit from constructing their work using this particular theoretical orientation and employ a range of additional theoretical perspectives within such a framework. The EMCDDA note that resilience results from a complex interplay of factors it can be built in communities by utilising a multi-pronged approach that targets improvement of the general environment, developing social skills, offering opportunities in education and training and assisting families in difficulties (EMCDDA, 2008, p.13).
The project's values are firmly rooted in (rights based) youth work; the voluntary and active participation of service users is a core concept in both the project and Youth Work Ireland Cork's ethos. This value base is evident in the professional approach of the staff to their work and the manner in which this work is conducted.

In terms of youth work praxis the project adheres to a personal development model (Hurley and Tracey, 1993) in its work with the drug using young people; this changes dramatically into a more radical and progressive model when the Cork Urban Skateboard Project is taken into account. Here we see the project operating from a rights led (rather than needs led) model that actively politicises young people. This is consistent with current ideas in the field of youth work praxis as a method of furthering young people's meaningful (as opposed to tokenistic) participation in civil society. This aspect of the project's work featured in a recent pan-European research project funded by the European

Commission under the Framework Six series of social research
(Up2Youth, 2008/2009, see http://www.up2youth.org/).

A strand of community work is also evident in the project's operations although this would not be readily visible. Within the broad parameters of community work the project's activities are located in the community development model (see Burgess, 1996).

Overall, the projects theoretical basis is akin to liquid rather than solid insofar as that it finds the space and moves to fill it. In so doing dogma and rigidity are rejected whilst flexibility and creativity are embraced; problems are approached as issues to be resolved through the involvement of the service users and staff in a collaborative process. No definitive method or model is championed as being superior to another and the workforce displays a willingness to try different approaches and methods to the tasks. A strong degree of pragmatism underpins the praxis observed in the project, further highlighting the harm reduction element of the project.

Practice Methods

The projects core method of work centres on the relationship between the individuals concerned. Theoretically, a meaningful engagement with a worker begins the process of trust building and allows for the worker to support, challenge, confront and assist the service user in making beneficial changes to their life situation.

This process requires solid and well developed youth work, counselling and communication skills. Various overt activities are undertaken to allow these relationships to develop, the

shared experiences in activities such as outdoor pursuits, sports, arts and crafts and everyday interaction serve as reference points and situational models for discussion and analysis of life situations including substance use. In practice with 'at risk' young people the European Centre for the Development of Vocational Training (CEDEFOP) point out that;

> *"A relationship with a trusted support worker, such as a mentor or a personal advisor, is one of the most effective ways of helping a young person through a transition point. Such support, however, is not available to many young people due to high delivery costs"* (2010, p.141).

Trips away are also undertaken; participants in these trips have an active role in deciding where they go and what they do. Aquapuncture provided by one staff member and the project is involved in the 'Strengthening Families' Programme.

Communications observed included a strong level of implicit understanding qualified by direct questions if the worker (or indeed service user) was unsure of exact meaning; i.e. *"what exactly do you mean by that?"* The knowledge of local linguistic codes is a tremendous asset in allowing for meaningful and rich communication; this is a noteworthy characteristic of the project.

Humour was used to both defuse potential conflict and to confront and challenge behaviour and belief. Humour is also employed by the staff as a coping and defence mechanism.

Given the sometimes disturbing level of trauma[20] the workers deal with this is unsurprising and indeed a healthy release for stress (Edwardo De Bono (1970) pointed out the reciprocal linkages between insight and humour, even when there is nothing funny about the situation), it serves an additional purpose as a creative tool for analysis and planning.

The workers appearance comes into play at this point; apparently mundane issues such as their choice of clothing can convey powerful messages to the service users. The casual, informal and laid back appearance of the staff contrasts with the more formal attire that service users expect from their experiences with state agents in the past and reflects an inherent understanding of the habitus of the neighbourhood (Koprowska, 2005, p6/7). Indeed, the workers are often taken as service users; a situation that the workers regard as a positive indicator of communications effectiveness.

The projects work and work methods with service users can be sub-divided into a number of core areas;

1. Preventative; focused on delaying[21] and minimising first legal drug use (such as alcohol) and countering the attraction of illegal substances. A comprehensive approach is employed in contrast to the semi-traditional '*just say no*' orientated programmes

[20] One staff member told us that in one house that he visits he always makes sure to sit in an alcove lest the occupants drug dealing enemies shoot through the (always open) front door into the kitchen.
[21] See Jackson's (1997) report; delaying first use can be a critical element in a person's future drugs trajectory.

targeted at young people that are at best a dismal failure and at worst counterproductive (Kiely and Egan, 2000, 237). It would be naive to expect that preventative work can somehow stop young people's entry into drug use; the strategic imperative behind this form of practice is to raise protective factors at an appropriate age. The delaying of use initiation and the raising of awareness around the effects of particular substances are crucial tactics in the heightening of protective factors.

2. Educational; focused on the provision of accurate and factual information on drug use and related issues (such as sexual health). This are also provides information on services available. In 2005 the project produced a magazine/comic 'Incider head'. Facilitated by Anthony Ruby, the SPY project's VEC arts tutor, the work was done by a group of 14 and 15 year olds and funded through the U4EA YPFSF money.
3. Working with individuals; this branch of the work can place high demands on the project staff. It is concerned with providing 'support packages' that take individual circumstances into account and is tailored to suit the individual service user. The focus is on assisting the individual to stabilise their life and to begin to make progress. Individuals can have difficulty keeping appointments with people turning up at the wrong time or on the wrong day being common. The workers frequently visit service users in their own homes, especially if a high level of support is required at any particular time. Crisis interventions would also slot into this category of the project's work.

4. Working with groups; the project runs a variety of groups to offer specific services and supports to the group participants. Such groups include the 'Friday group' (comprised of high level service users), the 'concerned persons group' (focussed on providing support for the families and friends of service users), aftercare groups and social orientated groups that partake in activities such as outdoor pursuits, arts and so forth. Theoretically, the work with groups closely (and apparently coincidentally) reflects Corey and Corey's (1997, p.355) ideas around the key elements of good practice in groupwork; fostering hope, developing belonging, focusing on the immediate, reinforcing appropriate social skills, and developing image change (i.e. from a 'junkie' or drunk no-good to a 'normal' person).
5. 'Contracted' groups; these are groups that have been constructed in collaboration with other agencies and include 'the ASBO gang' (referred by An Gardai), the Diamond[22] women and the Emerald girls programme. The project is involved in this work due to its expertise in the youth and drugs areas. Family work; the focus is on supporting and assisting the families of service users, some of whom are 'on holiday' (in prison or residential treatment).
6. Miscellaneous; this area of work comprises a variety of tasks and roles that the project engages in and includes the skateboarding project and activities such

[22] 'Diamond' is a residential facility outside of the Gurranabraher area in which the project workers engage in offering support and information in relation to drug/alcohol issues. In order to preserve agency confidentiality the term 'Diamond' is used rather than the intervention's true name.

as accompanying parents to visit service users in residential treatment centres.

7. Administration work; this branch of the work includes meetings, regular staff supervision (provided by the project manager), planning, accounting and so forth.
8. The 'brief intervention group' The project, in collaboration with other Cork City Local Drugs task Force Projects[23], operates this programme for approximately 14 individuals referred in from participating projects. This particular programme originated as a collaborative effort involving a number of Dublin based agencies targeting cocaine users. Entitled 'Reduce the Use' (Cafferty, Gardner and O'Connell, 2007) this work utilises the theoretical constructs from 'Brief Solution Focussed Therapy', underpinned by cognitive behavioural therapy, to assist the group members. Barber (2002) points out that in drug dependant situations 'we' assume that more therapy/intervention is better, but that "*there is actually very little evidence to support this assumption*" (p.123). All other factors aside, a short course focussed on drug use can therefore assist service users in making positive changes in their life situations.

Regardless of the particular method used, service user progress is measured in an informal manner; the staff works with the individual service users across the various areas of their lives and see how situations can be improved. In this

[23] The Mahon, Traveller Visibility Group, Ballincollig and Farranree projects, and Arbour house.

regard the focus is not solely on drugs use; the five social areas mentioned earlier all feature. This is commensurate with a holistic, creative and systemic approach in which a positive development (such as accessing a training course or getting a flat) has a knock-on effect into other areas of a person's life. The liquidity of the approach is visible here insofar as any area of a person's life can be a fruitful starting point. Barber (2002, p.48) recognises the value of both individualised feedback and an emphatic, non-judgemental approach as employed by the project.

A person's wider environment and social systems are taken into account and life areas are not split into (easily) categorised compartments. This approach is qualitatively effective in operation yet difficult to evaluate in a quantifiable manner as it cannot and does not tick boxes that indicate progress. A person's situation can change rapidly in a short space of time and the project staff has to be cogniscent of the infinite quantity of variables that impact upon the service users lives.

This contrasts with more rigid programmes (such as the 12 steps) which follow a prescribed pattern. The brief intervention group mentioned above is a case in point in that the project workers took the original programme and adapted it to suit their own group's needs whereas a similar brief intervention group operated by counsellors opted to apply the original programme verbatim.

Weekly Schedule (Typical)

To give the reader a picture of the form and nature of activities and operations in the project the schedule below was compiled from the project's activities from the week

commencing Monday February 22nd 2010. The project doesn't open to the public as such; usually the staff members operate to their own timetables and in keeping with the outreach foundations of the project their physical location will vary according to their workload.

Monday;

Morning; administrative work (which can be put on hold if necessary) and response to the weekend's events amongst service users

Night; concerned persons (parents) group

Tuesday;

Afternoon; #1 aftercare group

Wednesday;

Morning; parents (women) support group

Afternoon; Emerald programme

Night; ASBO group, football

Thursday; 'One to one' day, typically 16 to 18 individual sessions.

Worker 1; 6 appointments

Worker 2; 4 appointments

Sessional Counsellor 1; 2 appointments

Sessional Counsellor 2; 4 appointments

Friday;

Afternoon; the 'Lads' group, (an 'Aqua Detox' session was on this week)

Saturday;
Afternoon; #2 aftercare group
Evening youth group (under 14s, preventative focus)

It should be noted that these activities represent the planned operations of the project; on the week that the research team was in situ a worker was due to accompany a young service user to a treatment centre in Dublin, and another worker was taking an under-18 to a counsellor near Capwell. Monday mornings are kept free so as to be able to deal with the emergencies and traumas that have occurred over the weekend (on Wednesday the 24th of February two workers had to separately take service users to the accident and emergency room in the Mercy hospital).

The workers informed us that we had arrived in a 'lull'; all the heroin users were more or less ok and no great drama was brewing to the best of anyone's knowledge. Two weeks previous to our fieldwork a 'mad Monday' had occurred during which staff had been responding to a variety of individuals with issues such as attempted suicide, domestic violence and criminal activity of one sort or another.
At other times the workers will be away for weekends with groups. The project shuts down in August. This is traditionally a quiet time and allows for the workers to take a complete break from the project.

Exit Routes
Service users move on from the project in a number of ways; some individuals don't move beyond a first contact scenario

and a small minority are reckoned to gain no real benefit from the project and drift away from the service. The project staff aim to be clear to individuals about what their (the staff) role is and what the project can and cannot provide. People move on to treatment centres (such as Arbour house and the HSE counselling services in Church street), move away from the area, fall into more dysfunctional and damaging drug use, go to prison or cut down/modify their use to a reasonably safe level. Tragically and unfortunately a number of service users exit through overdose, suicide and violent non-accidental injury.

Success is evaluated as a relative concept; a person who modifies their use or indeed their lifestyle is viewed as a success. Younger people who manage to re-orientate their transitional trajectories away from harm and/or move towards a solid identity formation are another success. At least one (former) service user has progressed into third level education.

Networks

The project liaises with a wide range of services concerned with both drug use and young people. Agencies such as An Gardai, Emerald, Arbour house and other Local Drugs Task Force projects feature strongly in this regard. The project also works with 'Meithal Mara', a boat building project located in Cross's Green.

The project staff felt valued by some of the other services and reported good relations with these entities. However, this was qualified in relation to some agencies; *"I feel medical bodies see us as a pain in the neck, I feel that the social work department think we work for them*" (POC). Despite this,

such agencies continue to refer potential service users to the project. Interaction with state agencies is (usually) on a formal basis although some informality and personal contacts exist.

The youth network group represents a firm set of agencies with which the project cooperates on a regular basis in both a formal and an informal manner and operating under the Youth Work Ireland banner gives the project access to a national network. The Youth Work Ireland Cork board of directors gives the project ready access to another group of networks, including University College Cork; additionally, YWIC regularly hosts student placements for this institution.

The sharing accommodation with the SPY project in a local community building allows the project to keep its metaphorical finger on the local pulse; in this regard everyday conversations with the community development project, HSE office and the caretaking staff offer the workers an invaluable source of up to date local news. The workers are conscious of the need to separate gossip and small talk from pertinent information.

Liaisons are generally affected if and when they become necessary; the project worker is well aware of the phenomenon of endless network meetings eating into a practitioners time and energy; one could spend an entire week doing little else if choose to do so, especially when one considers the plethora of relevant organisations and agencies working on the Northside of Cork city. With this in mind, liaison and networking is conducted in a utilitarian fashion; the project must gain from it, otherwise it serves little or no real purpose.

Chapter 5 Project Evaluation

1 Meeting the Project's Original Aims and Objectives

The project's original core aims were;

> *"(1) To support existing youth initiatives and (2) develop responses to the needs of young people from the area involved in or at risk of becoming involved with drugs".*

The project's development and its current operations indicate that these aims have been met in an effective manner congruent with the principals of high quality youth work.

Whilst still fulfilling the mandate of these original aims the project has moved beyond its original brief and in this regard and can now be seen be effectively responding to the (1) developing needs of its geographical catchment area and (2) the wider needs (in conjunction with other agencies such as Emerald) of the Northside area of Cork City. Service development has been organic rather than mechanical.
The drug ecology of Cork City has changed since the project's inception and this is reflected in the age profile, substances used and ancillary issues of the service using population. The staff and management have proved to be creative and timely in responding to changes in the local drug ecology.

Attention will have to be given to injecting drug becoming more prevalent and to addressing the issues raised by this state of affairs. Stellamans (Unpublished, in EMCDDA, 2010, p.15) research indicates that the desire for a greater effect

was the principal initiator of injection use. Other predicators were dependent upon age (with younger users being more at risk) social, environmental and familial factors.

Furthermore, Stellamans work suggests that prior to initiation into injection use an increase in consumption frequency and quantity ranks heavily as a warning sign. The project will require a specific injection strategy if the developing trend continues. At this point in time it has been suggested by the staff and management that a targeted initiative towards women and girls in relation to heroin use may offset the impact that the emergence of an injection ecology could have in the Gurranabraher-Churchfield area. Moreover, worker safety will become a critical issue if needle use becomes common.

A danger of overstretch is however evident; the staff team are dedicated and professional and will need to put down boundaries on the level of new work that they take on. This is the 'other side of the coin' in relation to the team's value base. Overstretch has been avoided thus far through the enlistment of volunteer workers, staff training and development and the subsidy of the project's budget through central (Youth Work Ireland Cork) funds.

At this juncture it is evident that the project requires a new and detailed set of aims and objectives to guide it through the coming years. New challenges will emerge and a reduction in resources cannot be ruled out given both the current economic situation and the apparent shift toward medical orientated interventions.

Required Action (i) The project needs to develop new aims and objectives to frame its work in the medium to long term. The developing need at this point in time centres on heroin use. Therefore, tactical responses to injection use will need to be devised to protect the health and well being of the staff and an overall strategy to address injection will be required. In this case it would be prudent to formulate such a strategy and tactics in advance of the phenomena.

2 The Mission of the Sponsoring Agency

The ethos and practices of the of the sponsoring agency's mission statement; "*to provide a community based response to young people's needs by offering them the opportunity to contribute to and participate in social, educational, artistic and recreational activities*" (Youth Work Ireland Cork, 2010) are evident in the project's operations.
The issue of working with persons who are no longer 'young' requires clarification. Ethically, the project is not in a position to cut ties with the small percentage of people who engaged with services 20 or so years ago (to use an extreme example) and who, for whatever reason, continue to use services (albeit usually on a sporadic basis).

Service users have built up relationships with workers and the project; one could venture that independence and self-reliance (or indeed referral to 'adult' services) should be the exit route for all service users. Most of the service users do indeed move on but not all and it is in this instance that clarification is required. Should there be an age specific exit time? There are grave issues at stake in this regard as those who don't move on are most likely the group with the most needs. The dilemma therefore exists of a youth work

intervention working with middle aged service users. Without prejudicing the outcomes of any discussion on this matter it may be that an approach such as the development of an off-shoot 'older' programme may address this issue.

Required Action (ii) Discussion and clarification is required in relation to the position of older service users.

3 Congruence with the National Drugs Strategy

The project was initiated under the National Drugs Strategy 'Building on Experience, 2001-2008. In the treatment[24] pillar this strategy prioritised *"progress towards a more fully integrated and holistic service"* through;

- *"The expansion of available treatment types and*
- *The provision of additional treatment places"* (Department of Tourism, Sport and Recreation, 2001, Section 6.4.1).

The project can be seen to be a holistic intervention and its inward and outward routes demonstrate it to be integrated into the ecology of service providers in the Cork area.
The *de facto* work of the project places it under two pillars of the current 'interim' (2009 – 2016) National Drugs Strategy, (1) Prevention/Education and (2) Treatment. In relation to preventative work the project is focussed on secondary and tertiary prevention (3.57, National Drugs Strategy, 2008);

[24] At the time of the strategy's publication the definition of treatment tended to be narrow; i.e., focussed on detoxification and methadone type interventions. This definition has broadened.

working with young people who if not already drug users are deemed to be at high risk.

The project and the sponsoring agency's operations, ethos and mission are congruent with the National Strategy. The Gurranabraher YPFSF and SPY projects overall practices mesh into the preventative strand of the Strategy in relation to the objective of increasing protective factors and reducing risk factors amongst the general youth population of a disadvantaged community.
This 'blanket' of Tier 1 service, in conjunction with the services provided by other agencies (after schools groups for example), in the main frees up the drugs project workers from primary preventative work (such as schools talks).

The National Strategy recognises the importance of such work with the strategic objective *"to prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use"* (p.96). The relevant performance indicators of this objective equate with the projects current approach although these indicators have statistical targets which may not be realistic.

The treatment aspect of the project currently meets the National Strategy's performance indicators of a speedy entry to treatment;

> *"100% of problem drugs users accessing treatment within one month of assessment by 2012"* and *"100% of problem drugs users aged under - 18 accessing treatment within one week of assessment by 2012"* (p.97).

However, the project's ability to respond virtually instantaneously to new or re-engaging service users is predicated on the staff's devotion to duty. The potential for worker burnout is very high; it has not happened to date but should be a matter of grave concern. The dilemma for both staff and management is apparent; if the workforce curtail their availability the 'golden moment' of opportunity to engage may be lost, if they continue to offer immediacy their ability to offer a high quality service may well diminish due to exhaustion and ultimately they will burnout.
The project's operations are currently achieving the aims and objectives of the National Strategy[iii] in meeting the needs of the local drug using population through the variety of measures detailed earlier.

Required Action (iii) The project needs to maintain its congruence with national policy in relation to its operations and resources. The project management and staff urgently need to address the danger of worker burnout through over-work and overstretch. In this regard, the ability of the project to respond may need to be sacrificed unless further resources are forthcoming from funding bodies.

4 Congruence with the Local (Cork City) Drugs Strategy

The Cork Local Drugs Task Force does not have a strategy in place at this point in time. A strategy has been in preparation since 2007 (Cork Local drugs Task Force, 2007); there appears to be little clarity as to the current state of affairs in this regard, with the newly launched (Irish Examiner, 12/10/10) Cork Local Drugs Task Force website giving no details (http://www.corkdrugsinfo.ie). The absence of a strategic

plan is a worrying issue insofar as that the central plank of local policy that should guide the project is open to interpretation. In this respect the project has little option but to frame its work in reference to the national strategy and the principals of good practice in the relevant disciplines.
Given this situation, the project management (in conjunction with other voluntary and particularly youth work organisations) should endeavour to input a strong, empirical and theoretically valid youth work perspective into this strategy.

Required Action (iv) Youth Work Ireland Cork, through the appropriate channels, needs to champion both a youth work and harm reduction approach to drugs work in the Cork region. Furthermore, both the project and YWIC should resist the trend towards a solely numerical referral based valuing of the project's work and actively seek to promote a local and social perspective in any developing local drugs strategy.

5 Congruence with the National Youth Work Development Plan

As the core policy framing youth work policy in Ireland the National Youth Work Development Plan can be taken as the benchmark document for praxis. This plan is in effect the policy driver emanating from the Youth Work Act 2001, an Act that Powell et al note;

> *"put youth work in Ireland on a statutory footing and placed statutory responsibility for youth work development and coordination with the minister of education and science on a national*

> *level and with the Vocational education Committees (VECs) on a local level*" (Powell et al, 2010, p.76).

The Act stressed the role of Youth Work in addressing social disadvantage as is found in the Gurranabraher–Churchfield community. The development plan's main goals, to facilitate participation, contribute to the reduction of social exclusion, extend and expand the infrastructure for youth services and to enhance professionalism and quality in the youth work sector (National Youth Work Development Plan, 2003, Goals) are being met in the project.

As a member youth service of Youth Work Ireland, the project and sponsoring organisation are also required to conform to the overall strategic direction and objectives of this (federated) organisation (Youth Work Ireland, 2009, p.16)). The current practices and policies of the project are in line with these objectives and strategic direction.

Additionally, both the sponsoring agency and the project appear to be operating to a high standard of international best practice in the field of community youth work and achieving what can be described as a 'Pan-European Policy Foci for youth policies; the transmission of a broad European value code, the (formal and informal) education of young people, the reduction of racism and xenophobia and improving the general health and well being of the youth population (Leahy, 2009, p.189).

6 The Service User Perspective

The service users interviewed during the fieldwork element of this research reported a very high level of satisfaction with the project and its staff. The immediate response theme was mentioned on a number of occasions, alongside the high level of trust that service users come to place in the workers. One interviewee stated that the project *"took away the fear"* was "*non-intimidating*" and that the workers were *"normal people"*. She did however state that they could "*push more within reason in terms of setting goals and guidelines*" (SM). She also said that a project extension in the form of aftercare and training courses would be beneficial. One individual described the principal worker as "*my saviour really*". The service users reported a strong degree of comfort and security in the project.
The physical location and access to the project are an area that would benefit from some change; on balance, the location is good and would be improved by (A) more office space, (B) a dedicated discrete entry route, and (C) a physical presence in Churchfield.

<u>Required Action (vi)</u> Every effort should be made to maintain the status quo in the area of meeting service user needs. The issue of immediate response versus staff overload requires immediate attention. Attempts should be made to source a Churchfield premises.

7 The Project's Impact and Relations with the Local Community

The project's work is perhaps best envisaged as a continuum of activities that encompass prevention, intervention, harm reduction, and community based treatment as the core tactical responses. No one activity is lionised as superior (demanding more expertise) than any other; indeed a 100% success rate in prevention would negate the need for the other activities. The inherent fallacy of a 'numerical-referral' value bias through the tier system is obvious in this regard. The concept of resilience is useful here; the Gurranabraher-Churchfield project, in conjunction with the SPY project and Youth Work Ireland Cork actively builds resilience to substance based problems through its activities in the locality. This is in keeping with the EMCDDA's perspective on helping the inhabitants of disadvantaged communities;

> *"Community level programmes aim to increase resilience in deprived and marginalised neighbourhoods by improving the general social environment for children, and by increasing community cohesion and group identity….Intervention studies with these three components –implemented through community mobilisation, parent and youth training, early intervention services and follow up case management-have shown positive effects on young people and family resilience, and also moderating effects on onset and frequency of alcohol and drug use"* (Johnson et al, in EMCDDA, 2008, p.15).

Youth Work Ireland Cork's longstanding presence and high regard in the community is undoubtedly a key element in the project's success. Allied to these facts are the good working relationships that the project enjoys with other agencies operating in the Gurranabraher/Churchfield area.

<u>Required Action (vii)</u> The project, in conjunction with the other Youth Work Ireland Cork interventions in this neighbourhood, should endeavour to maintain its high standing in the local community and its solid links with other agencies.

8 Evaluation Conclusion

In terms of an overall evaluation of the project it would seem that it is a remarkably successful example of good practice in the areas of youth, community and drugs work. We received virtually no negative feedback from any source in relation to the project or its sponsoring organisation. The success of the project can be located in a quintet of inter-related factors;

- Staff; the combination of experiences, qualifications, skills and similar value bases of the staff group allied with a more or less implicitly understood and clear sense of mission result in a motivated and able workforce. This particular workforce has demonstrated a clear ability to respond in a creative and effective manner to the changing drug ecology of the community in question. A difficulty does exist in that the departure of such workers from the agency could have serious repercussions for the project's operations as any subsequent workers will need a lengthy period of time to become effective.

Notwithstanding this qualifier it should be recognised that Youth Work Ireland Cork's overall perspective on staffing is that the very nature of youth (and drugs) work demands a staffing model which recognises the centrality of the reflexive practitioner as paramount. The notion that projects can be structured in such a manner as to facilitate a seamless transition between workers is, in the experience of Youth Work Ireland Cork, groundless and indeed fails to acknowledge the reality of this work. The current workforce is highly competent in the areas of knowledge, skills and values required for professional practice in a youth/drugs/community setting (O'Hagan, 1996).

- Management; in a similar vein, the management group possess a highly relevant set of qualifications, skills and other assets that assist the project's work. Of note in this regard is the role played by the Director, David O'Donovan, in the provision of professional supervision to the staff group. The management does however have ultimate responsibility for the health and well being of the workers, paid, voluntary and sessional, and in this regard the matters connected with over-work need to be swiftly resolved.

- Structure; the project is structured in a manner that facilitates that extracts the maximum value from the available resources. The delegation of tactical decision making to the frontline staff and the inclusion of frontline staff in strategic decision making within a clear set of operational guidelines

(the youthwork ethos) evidences a high level of trust from the directors to the staff and a consequential high level of commitment from the staff. The structure is flexible and allows for quick decision making, a vital feature in a dynamic environment.

- Theoretical Clarity; the project benefits from having a high degree of theoretical clarity in relation to youth work, drugs work, and a range of related topics. The project is firmly rooted in a social perspective on drug use and on problematic drug user. The import of such clarity cannot be underestimated as it forms a solid yet flexible foundation for the project's operations and it is manifested corporally as the project's purpose. Everyone involved knows what the project does and why it does it.

- Historical Relationship and Trust in the Local Community; the high esteem of the Youth Work Ireland Cork interventions in the neighbourhood represents a priceless asset. The praxis of the project is built on the relationships that the individuals involved hold with the local community. The long term presence of Youth Work Ireland Cork in the neighbourhood acts as a pre-existing engagement mechanism for local young people (and indeed adults). The adherence to what Kiely (in Kiely, Forde and Meade, 2009) describes as youth work's 'traditional code of voluntary engagement' and the eschewing of coercion represents a tangible measure maintained by the project in a field that does resort to forced intervention in the form of court orders and probationary conditions.

Moreover, and especially pertinent given Ireland's strained financial circumstances, one must conclude that the GCDOP represents excellent value for money. Although it is outside of the remit of this study to engage in a costs-benefits analysis the simple arithmetic of 69 high level service users in a 10 month period for a project with a budget of 66,000 euro is stark insofar as that it costs less than 1,000 euro per annum per service user[25]. This is without factoring in a host of other activities and a myriad selection of less tangible but still very real benefits to the local community, Cork city and indeed the civil society as a whole.
The overall impact of a project such as the Gurranabraher-Churchfield Drugs Outreach Project cannot be quantified in monetary terms as operating in the social world involves countless variables that do not possess a monetary value. Ranging from the building of social, civic and community capitol, through preventative work and on to radical work in the form of the skateboard project, these variables are difficult to measure but the effect of their absence is readily visible in crime, suffering, disease and need.

In sum, the project's success is founded on the people involved and the youth work derived ethos that guides the practice.

[25] This funding contrasts with a cost of prison places; "*the average cost of providing a prison space in 2009 was €77,222 this was a decrease on the 2008 cost (€92,717) of €15,495 or 16.7%*" (Irish Prison Service, 2010, p.4).

Chapter 6 Feasibility of Expanded Services

The issue of the project providing a more comprehensive service was raised during the course of this research study. In the main, this report cannot comment in any great detail as far too many variables exist in this realm for accuracy to be maintained. Service development in the form of expansion was discussed with interviewees during the fieldwork and a number of areas emerged as possible vehicles for future service extension.
The form that such an extension of services might take can be broadly divided into a number of areas;

1. The provision of a detoxification facilities within the geographical area
2. The provision of dedicated drug services such as methadone maintenance and needle exchange
3. An extension of the project's working hours
4. The provision of an alternative or satellite premises for the project.

At this juncture it is difficult to assess just how feasible the first two areas would actually be. O'Driscoll (2010) points out that there are currently no residential detoxification facilities for young people in Cork, illustrating the need at a city level for such measures. Numerous obstacles may exist to such a provision in a youth work setting as the delivery of these services might well shift the project away from a social model and into a more (1) medical/health paradigm and/or (2) social care model of practice (in a residential detoxification setting). The EMCDDA (2010A, p.57) point out that needs, resources and theories have to coalesce if the pitfalls of over-extension are to be avoided; notwithstanding the financial

requirements such a development could present a rift in theoretical approaches within the both the project and the sponsoring agency.

The capacity of Youth Work Ireland Cork to manage such interventions is open to question and the possibility to access funding to resources is very much doubtful, particularly in a time of economic uncertainty and a reality of resource cutbacks. A need for such interventions does exist; it may be more appropriate however for Youth Work Ireland Cork to collaborate with other agencies, the local community and the Local Drugs Task Force in seeking to have such facilities located on the Northside yet operated by a more relevant agency.

Extending the hours of the project is conditional on the acquisition of further resources. Given that the Local Drugs Task Force monies pay the salary of only one worker it is feasible to suggest that this project should have a second post funded. Youth Work Ireland Cork is currently bearing the financial costs from a central budget; the Drugs task Force can and should contribute more resources in this regard.

The acquisition of a satellite premises in the Churchfield area would be of undoubted benefit to the project in providing an enhanced service. There may be a temptation in this regard to apply for a new dedicated Churchfield Drugs Task Force Project. This should be avoided as such a development could easily lead to a duplication of work in the administrative sphere with no benefit accruing to the local community, service users or service providers.

Whilst broadly in favour of expansion the service users regarded some areas as unwelcome, particularly needle exchanges, referring to dirty needles and the encouragement of injection use as potential dangers. Expansion into this area might also generate resistance in the community. Presently, the nearest needle exchange is in Waterford; however a roll out of pharmacy based needle exchanges across the HSE South region is planned for in early 2011. Services such methadone maintenance, urine testing (which is already in place), residential rehabilitation, information provision and counselling were viewed as desirable. Methadone is currently available at two sites in Cork, through the Simon (homeless intervention) Community's GP and at Arbour House. These views equate in the main with the views of the workers and management (although some staff did express the opinion that a needle exchange was feasible).

What are apparent are the changes that occur in the local drugs ecology. These changes may require a reorientation rather than an expansion of services. The issue of young female heroin use is a particular worry to the project at this point in time; particularly amongst the Emerald girls. The substances used are also subject to change; prior to the completion of this study service users' reported that crack cocaine is set to enter the local ecology as dealers are aggressively marketing crack by offering free samples to users. The use of headshop type legal highs has fallen dramatically; these developments highlight the dynamism within the local drugs ecology and the rapidity of change in the substances used.

<u>Action Required</u> (viii) Management and workers need to initiate a strategic review of the project in order to arrive at a

new set of concrete and realisable aims and objectives for the project. Such aims and objectives need to contain a mechanism that allows the project to continue developing and expanding within agreed parameters. Any new strategy should also allow for changes in the local drugs ecology. As Youth Work Ireland Cork is currently devising a new strategic plan for the entire organisation this would seem an opportune time for the project to formulate its future direction.

Additionally, further research into the provision of services such as needle exchanges would be required before an informed decision could be taken in this field. In this regard, fact finding trips to other cities in Ireland, Britain and Europe would be desirable.

Chapter 7 Conclusions

The Theoretical Construction; Transference to other Community Youthwork Locales

The Gurranabraher-Churchfield Drugs Outreach Project can be perceived as a particular social system within a broader social milieu. Two other systems primarily shape the project's existence, philosophy and practices;

- The local community in which the project is set, Gurranabraher-Churchfield
- The sponsoring organisation, Youth Work Ireland Cork

Additionally, entities such as the Local Drugs Task Force and policies such as the National Drugs Strategy underpin and impact on the project.

Within contemporary Ireland the socio-cultural milieu of Gurranabraher-Churchfield is undoubtedly a disadvantaged area. Deprived and marginalised areas tend to accumulate problematic drug use due to the preponderance of risk over protective factors. Although psychoactive substance use is in itself a risky activity most people in society who use such drugs (usually in a recreational manner) do not develop long term problems.

Young people are especially prone to experimenting with substances and over-using for a variety of reasons. Additionally, illicit drugs are now freely available and there use has become normalised over the last few decades at all stratums in Irish society. Adolescent risk taking is normal and

"*entails some chance of loss and tends to be high in novelty and intensity of sensation*" (Lalor, de Roiste and Devlin, 2007, p.117). However, the young person from a disadvantaged background (as exampled by Gurranabraher-Churchfield) is therefore acting in a particular social environment that features a heightened set of risks. Despite this heightened risk most of the young people do not develop serious drug related issues; however, a significant minority have difficulties connected with their drug use.

Society can respond to this situation in a number of ways; the youthwork community drugs project approach is one. For this approach to be successful a number of prerequisites need to be in place;

- A clear theoretical approach rooted in a social view of drug use that encompasses youth, drugs and related factors;
- The establishment (or maintenance) of a physical presence in the community;
- The employment of skilled and experienced reflexive practitioners who can operate in a flexible and independent manner;
- An appropriate organisational structure that features the devolvement of decision making to the frontline;
- Signposted access routes for potential service users appropriate to the locality

In sum, these are the vision, the time, the people, the organisation and the access.

The Gurranabraher-Churchfield Drugs Outreach Project exhibits all of these prerequisites and can be perceived as a

solid example of good praxis in this field. Moreover, the strategy, structure, ethos and tactics employed by Youth Work Ireland Cork in operating this project are transferable to other locales and represent excellent an optimum benefit relative to the resources deployed.

Conclusion to the Research Study

The principal purpose of the project is to meet the relevant parts of the core aim of the national Drugs Strategy;

> *"To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research"* (2008, p.96).

The means employed to achieve these aims are a set of relevant methods drawn chiefly from youth and drugs work. The impact of the sponsoring agency is particularly influential in this regard and serves as the foundation for the projects work. From a drugs work perspective the project is successfully implementing a social model of practice grounded in the ethos and pragmatism of harm reduction. This particular approach does not dismiss abstinence outright; instead it offers (in as much as resources allow) a comprehensive set of options to service users tailored to meet each individual's unique needs.

A congruence exists between the harm reduction and social models employed by the project insofar as both approaches share a humanistic ethos that views people as having potential, as having a worth and value beyond economic

measure, as being entitled to make their own decisions (and not have decisions made for them) and of locating the overwhelming majority of social ills in the manifest social inequality that divides society.

In this regard the evidence from this research study can be interpreted as showing that the tier system, or perhaps a strict adherence to such a system, may not be the most useful or fruitful approach to problematic drug use in Irish society. A flat, non-hierarchal structure with transverse rather than vertical axis may represent a more effective and efficient organisational plan. Such an organisational structuring of resources would also negate perceived status injustices.

One could well make the argument that in addressing substance use issues the specialist expertise and skill lies at the bottom of the current tier system insofar as that the level of skills and knowledge required to engage with potential service users is of an extraordinary level and demands both implicit and explicit knowledge and skills in multiple areas. Even the seemingly simple matter of effective communication in a non-authoritarian manner is fraught with difficulty; the Minnesota Model response to this issue has traditionally been to enforce a ‘no-slang’ regime with strict sanctions. This approach negates the obligation on practitioners to communicate with the service user on their own terms and conflicts fundamentally with core youthwork tenets.

The hierarchical nature of the tier system represents a diminishing of other forms of knowledge, skills and values and attempts to impose a hegemonic medicalised viewpoint

at the pinnacle of drugs work. The issue of specialism betrays this challenge for dominance. The specialities exhibited in the case study project included a sophisticated set of knowledge around (amongst others) the local drugs ecology, outreach, engagement, communication, relationship building and maintenance, community and youth issues.

Although an expansion of the Gurranabraher-Churchfield project's services would appear to be unfeasible at this point in time there are no real obstacles theoretically to an expansion of services if resources were available. The employment of a predominantly 'local-social' model rather than a medical model in the area of problematic drug use can contribute to a diversity of approaches which will allow service users access to appropriate and relevant interventions.

Concluding Comments

This research study commenced by asking *can community based drugs projects effectively deliver services across the range of the 'tier' system currently employed as a key delivery mechanism in Irish substance misuse interventions* and *does the Gurranabraher-Churchfield Drugs Outreach Project deliver services to persons located across the entire tier spectrum?*

This evidence from this study suggests that such projects can and do operate at various sites in the tier structure. The Gurranabraher-Churchfield project most certainly works with service users from across the entire tier spectrum. The 'tentative' hypothesis advanced in the methodology section of this study (regarding the feasibility of community based

services working across the tiers) has been shown to be a reality.

From the findings of this study it can be concluded that most drug services (regardless of the actual provider agency) could be community located. Moreover, this approach would synchronise with the development of 'primary care teams' in the health sphere; although it is critical that community (and especially youth) interventions retain the local-social perspective as their primary perspective on drug use at all levels. With this point in mind it would not be possible or even desirable for such agencies to cover all aspects of drug use without fundamentally altering their own identity away from the social.

It should therefore be possible to position the community youth based drugs projects as centres of expertise in the field of harm reduction based drug interventions; for this to occur sponsor organisations may require a far more sophisticated and research based theoretical foundation from which to build their work. In practical terms, a key advantage that such projects possess over other interventions is their presence in communities and the relations that over time build between the project staff and the local people. These relationships foster the trust that is a prerequisite of success.

The fear amongst the voluntary, community and youth work drugs project personnel in relation to cutbacks and downgrading is very real. Cutbacks in this approach to drugs work would represent a giant leap backwards in Irish service provision and must be stoutly resisted by all concerned. It is ultimately the service users and their communities that stand to lose the most from such a development.

The rise of a numerical-referral approach to evaluating community based interventions on the basis of how many service users transfer up the tier must be resisted as it neglects the vital role played by these interventions at numerous levels.

It is therefore behoving on such service providers to make the arguments necessary backed up by evidence. In this regard the service providers themselves need to develop a more sophisticated theoretical understanding of the complexity of drug use and the multiple issues associated with drug use. Youth organisations in particular need to be able to argue from a community 'local-social' perspective rather than from legal and health perspectives which ultimately are the responsibility of other societal agents.

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Appendix 1; Service User Interview Schedule

Youth Work Ireland Cork Drugs Task Force Project Research 2010
Service User Interview Schedule

Section 1

Personal Details

Name (**False**) Length of time with project
Education/Qualifications Occupation
Additional comments

Section 2

Socio-economic Profile

Social Class (self reference) Gender Ethnicity
Living Arrangement (i.e. Home/Flat/Partner)

Locality of Origin Locality of Residence
Additional comments

Section 3

Perspective on DTF Project

1. What are the aims of this project?
2. What have been the main developments in this project since you have been involved?
3. What is your opinion on the physical location of the project in regard to its;
   (a) visibility, (b) access for services users, (c) other?
4. Is this project convenient for you?

Additional comments

Section 4

Intake

1. How did you become aware of this project's existence?
2. How did you decide that this project might be useful to you?
3. Would you think that your drug use is serious?
4. How has it affected your life in terms of (a) health, (b) finance, (c) housing arrangements, (d) work, (f) relationships, (g) other areas (please specify).
5. Are there any apparent patterns of drug use, in your experience?
6. What types of drugs were or are you using?
7. Why these particular drugs?

Additional comments;

Section 5

Core work

1. Who did you meet with first in the project?
2. What did you expect from the staff of the project?
3. Were your expectations realistic?
4. Did you set goals?
5. What did you think of the appearance of the workers and the project? (Prompt; was it welcoming?)
6. How do you get on with the staff?
7. How do you find the staff for (a) motivating you, (b) challenging you, (c) supporting you, (d) confronting you?
8. What type of stuff do you do when you're in this project? (Prompts, talk, listen, think, shout, eat).
9. Apart from the drug use, did you have any other issues? (b)If yes, please if you feel comfortable, specify these issues and (c) how does the project respond to other issues?

Additional comments

Section 6

Output

1. Do you think a time will come when you won't want to be here anymore?
2. If yes, how will you know when that time is?
3. For you, what would make your relationship with the people in this project successful?

Additional comments

Section 7

Liaison

1. Have you ever used any other drugs task force projects?
2. What about any other drug and alcohol service providers? (Prompts, CWO, GP, PHN, Arbour House).
3. Do you think that the project's work in valued by other services?

Additional comments

Section 8

The Local Context

1. How is the project viewed by local people?
2. How are the staff viewed by local people?
3. How are you viewed by local people?
4. Does Gurranabraher have a drug use reputation?

5. Do the local people view this area as having a drug problem?
6. Are there additional issues attached to drug use in this area (such as vigilantism)?
7. If yes, have you any experience of these issues first hand?

Additional Comments

Section 9

Service Gaps

1. What are the gaps in services for drug users in (a) this project, and (b) this community?

Section 10

Service Feasibility.

In your opinion, could the project provide the following services?

Needle Exchange
Counselling
Methadone Maintenance
Hard Information Delivery
Urine/Substance Testing
Alternative Therapies
Other Unidentified

Strongly Agree
Mildly Agree
No Opinion
Mildly Disagree
Strongly Disagree
Not Applicable

Respondents Commentary

Any other information, comments ideas (use back of sheet if necessary).

Appendix 2; Staff Interview Schedule

Youth Work Ireland Cork Drugs Task Force Project Research 2010
Staff Interview Schedule

Section 1

Personal/Professional Details

Name Position
Years with YWIC
Qualifications Experience
Additional comments

Section 2

Socio-economic Profile

Social Class
Ethnicity Gender
Locality of Origin Locality of Residence
Additional comments

Section 3

Perspective on DTF Project

5. What are the aims of this project?
6. What have been the key developments in the projects life since you have been involved?
7. What are the key theoretical ideas that inform your work?
8. What is your opinion on the physical location of the project in regard to its;
   (a) visibility, (b) access for services users, (c) other?
9. For the service using population, what physical infrastructure gaps exist in (a) in the project and (b) the community?

Additional comments;

Section 4

Intake

8. How do service users become aware of this project's existence?
   (a) Do people get referred in? If yes, (b) from who or from where?
9. How do you decide that this project is (a) suitable for a person, (b) unsuitable for a person?
10. How do you assess people's needs?

11. Who uses the project in terms of the seriousness of their drug use (refer to typology of use)?
12. Can you give an outline account of the (a) age range, (b) gender, (c) educational level, (d) occupational status, (e) housing circumstances, (f) involvement with criminal justice system, (g) general health and well being, and (h) personal details of the service using group?
13. Are there any apparent patterns of drug use, in your experience?
14. What types of drugs people using?
15. Can you offer an explanation form your practice as to why these particular drugs are being used?

Additional comments;

Section 5

<u>Core work</u>

10. Who decides that a person has 'issues' that the project can work with?
11. How does the project divide up workloads?
12. Do you use a 'keyworker' system?
13. What are the expectations of the service users upon engagement with the project?
14. Are these expectations realistic?
15. How do you (and the service user) set goals?
16. Do you have dress/appearance codes? Please elaborate in terms of reasons why.
17. How do you communicate with service users in terms of (a) motivating, (b) challenging, (c) supporting, (d) confronting?
18. What methods do you use in your work?
19. Do you perceive the work as any of the following (answer yes for all that apply);

(a) counselling, (b) youth work, (c) groupwork), (d) social work, (e) community work, (f) preventative work, (g) social care work, (h) screening for higher tiers, (i) information delivery, (k) family work, (l) therapy, (j) any other (please specify).

20. Do you operate any standard programmes (such as 'Walk Tall')? Please specify.
21. Apart from drug use, do service users (a) present with other issues? (b)If yes, please specify these issues and (c) how does the project respond to other issues?

Additional comments

Section 6

Output

4. Do you ever decide that (a) a person can no longer benefit from this project? (b) If yes, how is this communicated to them?
5. How do people usually exit the project?
6. Do you (a) maintain contact with former service users? (b) If yes, what form does this contact take?
7. Where do people move on to?
8. How do you evaluate your work with individuals as successful or unsuccessful?

Additional comments

Section 7

Liaison

4. Do you cooperate with other drugs task force projects?
5. Do you cooperate with other drug and alcohol service providers?
6. What other services do you network with?
7. In your opinion, how is this project viewed by these services?
8. Do you rely on formal channels or on informal contacts in liaison work?
9. Do you think that the project's work in valued by other services?

Additional comments;

Section 8

Management and Supervision

1. What is your understanding of the relationship between this project and the host organisation YWIC?
2. Does the management understand the nature of the work that you are involved in?
3. Does the management offer you the necessary support in professional and personal terms to work in this project?
4. Is the project represented at management level?
5. Are service users represented at management level?
6. Do you have access to supervision? If yes, please give details.

Additional comments;

Section 9

Funding and Resourcing

1. Where is this project located in terms of the Drugs Task Force tier system?

2. Do you believe that this tier location accurately reflects the type of serviced provided by this project?
3. Who funds this project?
4. Who has control over the manner in which the resources are allocated?
5. Do you think that this project is adequately resourced? Please elaborate in terms of personnel, resources, premises and other issues.

Additional comments

Section 10

<u>The Local Context</u>

8. How is the project viewed by local people?
9. How are the staff viewed by local people?
10. How are the service users viewed by local people?
11. Does the area have a drug use reputation?
12. How do local people view this area in relation to drug use?
13. Are there additional issues attached to drug use in this area (such as vigilantism)? Please specify.
14. How is drug use viewed in this area? See sheet D/A use 1.
15. How are drug users viewed by the local population? See sheet D/A use 2.

Additional Comments

Section 11

<u>Service Gaps</u>

2. What are the gaps in services for drug users in (a) this project, and (b) this community?

Section 12

<u>Service Feasibility.</u>

In your opinion, could the project provide the following services?

Needle Exchange | Counselling
Methadone Maintenance | Hard Information Delivery
Urine/Substance Testing | Alternative Therapies
Other Unidentified

Strongly Agree | Mildly Agree | No Opinion
Mildly Disagree | Strongly Disagree | Not Applicable

Respondents Commentary

Any other information, comments ideas (use back of sheet if necessary).

Appendix 3; Gurranabraher-Churchfield Sub-Survey Sheet.

Drug and alcohol use

1. Do you agree with the banning of;
   (a) cannabis,
   (b) heroin,
   (c) cocaine and
   (d) ecstasy?
2. Is there a problem with drug use in this area?
3. If yes, have you ever seen drugs being used in this area?
4. If yes, what sort of drugs did you see?
5. Should head shops selling legal highs be banned?
6. Do you know anyone from this area that uses illegal drugs?
7. Is it ok for people to use these drugs if they aren't hurting other people?
8. How do you think drug users should be treated? Prompts; criminals, patients, hospital, jail, rehab, church, left alone, whipped.
9. How do you think drug dealers should be treated? Prompts; as above but categorised thus;
   (a) low level dealing to feed habit,
   (b) low level dealing for friends,
   (c) mid level dealing to make a few bob,
   (d) high level dealing to make loads of money.

Any other comments on drug use in this area?

Appendix 4; Effective Praxis in Drugs Work with Young People; a Case Study

Excerpts from a Paper Presented by Emma Bennett and Aoife Farrell at the 'Working with Young People' conference, University College Cork, May 11th, 2010

Introduction

This paper is concerned with youth work's alternative and creative responses to drug issues amongst young people. The primary knowledge used in this paper is garnered from research carried out in February 2010 in the Cork Local Drugs Task Force (LDTF) project in the Gurranabraher/Churchfield area on Cork's north side. The paper will begin with a profile of the Gurranabraher/Churchfield DTF project. This will include a brief description of the area and its socio-cultural context as well as profiles of the service users and project workers. In order to contextualise the discussion on alternative responses to drugs service provision, the traditional approach to intervention in this field will be outlined. The operational procedures recommended by the DTF will be discussed in order to highlight the sophisticated and creative strategies employed by this particular agency. In theoretical terms, an overview of the models and methods underpinning these strategies will be given focusing on their effectiveness in terms of service delivery.

Research Context

This article is a preliminary output from research carried out by the School of Applied Social Studies, University College Cork and Youth Work Ireland Cork (YWIC). The purpose of the research is to examine the feasibility of locating a range of drugs services for young people in a community setting,

spanning the range of ‘tiers’ set out in DTF operational procedures. The research was qualitative in nature, and as part of the research methodology a number of semi-structured interviews with selected expert respondents were carried out as well as a sub-survey among random members of the public in order to ascertain local attitudes towards drug use. We feel that through focusing on personal experiences by means of qualitative research, the effectiveness of the project can be truly demonstrated. While data analysis is ongoing, this paper will use the Gurranabraher/Churchfield project as a case study and investigate the possible benefits to youth work of incorporating alternative responses in dealing with drug issues in the community.

Background Context

Area Profile

Gurranabraher and Churchfield are two neighbouring communities on the north side of Cork City. Gurranabraher was built in the 1930’s as social housing; Churchfield was built later in the 1950s, again as a social housing intervention. Historically, these two communities have suffered cumulative social disadvantage and issues such as unemployment, early school leaving, lone parenting and a high social welfare dependency rate feature strongly in the area. A sub-survey conducted as part of the research revealed that the overwhelming majority of respondents perceived the area to have a ‘drugs problem’, both the project staff and the local people perceive the area to have a high crime rate and an underlying fear of vigilantism is reported among the drug using population.

Project Profile

The LDTF project operated by YWIC in Gurranabraher has been running for ten years. Previous to this, the Cork Youth Federation (precursor to YWIC) had been running a youth project in Churchfield since 1988. The project has developed since then, changing premises a number of times, and has been located in the 'new hut' – a purpose built community centre – in Gurranabraher since March 2009. YWIC operates out of the third floor of this building where the DTF project has one dedicated office. The project employs a number of staff in both full and part time post to cater for the needs of young people in the area.

Service user Profile

Our research has found that the overwhelming majority of service users suffer cumulative disadvantage. While there is no such thing as a 'typical' service user, the research suggests that many experience social issues such as poverty, early school leaving and familial patterns of substance use. Service users present with drugs issues ranging from recreational use to chaotic use. Involvement with the criminal justice system is common with approximately 90% of chaotic drug users facing legal charges and numerous younger members of the project having ASBOs or cautions from the Gardaí. Housing circumstances vary among service users with some living with parents in social housing, others living in poor accommodation supplemented by rent allowance or in more severe cases, homeless. While the project's remit, as a YWIC intervention, is to work with young people, users up to the age of forty access services in the project – a testament to its needs-driven approach.

Traditional Approaches

Traditionally, on a broader societal level, policy and responses to drug use have been based largely on a prohibitionist model. This traditional, medicalised approach led to a 'war on drugs', the central tenets of which, according to Ruddle et al were;

> "*The implementation of legislation and the promotion of abstinence as the treatment response*" (2000; 13).

Policy developed with an underpinning moral-legal authority advocating tough criminal sanctions and a focus on demand and supply reduction. O' Shea argues that Irish drug policy "*has drawn its influence primarily from the United States and Britain"* (2001; 16) and that this has led to a prohibitionist approach being developed in Ireland where "*the focus and thrust of treatment was one of total abstinence*" (ibid; 17). This has several repercussions for the way in which policy is made and practice is carried out. To adhere to a medicalised viewpoint and consider drugs in isolation from other social issues, is to neglect the broader societal context which plays host to a multitude of contributing factors to a drug 'problem'. A narrow, medicalised approach overlooks contextual factors, curtailing effective policy-making and therefore intervention.

The Gurranabraher/Churchfield project is coordinated by the Cork City Local Drugs Task Force. LDTFs were set up in 1997 under the Ministerial Task Force. While the LDTF does recognise that services should be locally based and have participation with the community/voluntary sector, its recommended operational procedures such as the tier model still show a preference for a medicalised approach to service

delivery. Drug services in Ireland are moving towards a four tier model which acts as a framework through which to deliver services (National Drugs Strategy 2009 – 2012).
While located at tier three, the project does not limit itself to the tier system and indeed rejects the labelling and categorisation implied by dogmatic adherence to such systems as being simplistic, narrow, abstinence orientated and indeed dismissive of drugs work that does not ultimately involve treatment. All of the workers interviewed felt that the tier allocation does not accurately reflect the types of services provided by the project with the general consensus being that it covers the first three, if not all of the tiers. There is a fear that operational models such as the tier system may relegate youth services into a role as 'taxi driver for treatment centres' since services are increasingly assessed by the numbers of clients referred on to treatment/rehabilitation. For example, the performance indicators espoused by the National Drugs Strategy 2009 – 2012 defines success as 100% of problem drug users accessing treatment within one month of assessment by 2012 (2009; 9). As a result, the vital contribution made by community based drugs interventions is downplayed.

A culture of evaluation has developed (Moran et al. 2001; 42) and evaluation and assessment are now integral to any DTF process. From a medicalised perspective, evaluations that show a low referral rate can be constructed as demonstrating ineffectiveness. However, our research strongly indicates that the opposite is true; drugs issues are being dealt with skilfully in the community by expert and experienced practitioners. The youth work type response underpinning projects such as Gurranabraher/Churchfield should not be viewed as low-level or insignificant: the services provided

need to be valued for their scope and effectiveness in dealing with drugs 'problems' in local communities.

Social Perspective

A defining characteristic of the project in Gurranabraher, and a contributing factor to its effectiveness is the fact that it takes a broad, social outlook on drugs issues. As pointed out by Barber, expression must be given to the *'dual focus on person and environment'* (1995; 26). According to our research, project workers view substance misuse as symptomatic of deeper rooted issues and are acutely aware of the socio-cultural context and culture of drug use in the area. A range of environmental factors impact on substance misuse in the community such as poverty, gaps in education, housing and income, health and mental health issues and so on. The cumulative disadvantages in the community and the stresses of post-modern society require a holistic approach to intervention. Medicalised operational procedures relegate the social perspective to an auxiliary position and are therefore ill-equipped to respond when dealing with the complexities of substance misuse situations. In Gurranabraher/Churchfield, services are delivered holistically and, since the project is grounded in youth work, it rejects a medical or legal focus, instead adopting a social perspective which allows for broader assessment and intervention, enabling effective practice.

Gurranabraher-Churchfield Drugs Outreach Project Approach

Project Workers

The Gurranabraher/Churchfield project's model of work is centred on the skill, experience and motivation of the project

workers. Most of them are personally connected to the locality therefore local knowledge is employed as a primary source of information. A solid knowledge of the informal community infrastructure ensures networking through word of mouth; likewise, personal contacts form an invaluable resource. The project attempts to improve the lives of local drug users, young people and families.

On conducting this research, we have found that project workers use a multiplicity of models, methods and theories in their work. However, these ideas are not strictly adhered to since every person is seen as an individual with diverse and contrasting needs. It is a needs driven approach which focuses on empowerment and development of service users' potential. The significance of individuality resonated throughout the research project, with every worker emphasising that each person is unique, with their own personal concerns and it is essential that project workers are non-judgmental, compassionate and understand where the service user is at. Key theoretical ideas which shape the project's work include harm reduction and the Cycle of Change Model using a Rogerian person centred, and holistic approach.

Harm Reduction

Harm reduction is an increasingly influential concept in the area of drug misuse (EMCDDA, 2010). The introduction of harm reduction heralded a break from traditional prohibitionist approaches to drug use which focused primarily on abstinence. According to the International Harm Reduction Association (2009)

> *"Harm reduction refers to policies, programmes and practices that aim to reduce the harms*

associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than the prevention of drug use itself and the focus on people who continue to use drugs".

It is generally accepted that a drug-free society has never and will never exist (Davenport-Hines, 2001) and the focus has shifted to minimising harms and supporting the needs of users.
Exercising a harm reduction approach suggests a strong commitment to public health and human rights issues with success measured by the transformation in rates of death, disease, crime and suffering rather than rates of abstinence. The project employs many harm reduction strategies such as the provision of information, education and communication on the health risks associated with drug use, urine testing, counselling and alternative therapies such as acupuncture.

Cycle of Change Model

One of the key theoretical ideas that inform the work in Gurranabraher is the 'Cycle of Change Model'. This method was developed by Prochaska and DiClemente:

"*The model is 'transtheoretical' in that it owes allegiance to no one school of therapy but seeks to provide an integrative framework capable of guiding practice irrespective of the therapist's favoured approach*" (Barber, 2002; 26).

The Cycle of Change Model provides a structure for understanding how people change their behaviour and it is used in many community drug support agencies (Goodman,

2009). It is a cyclical process involving pre-contemplation, contemplation, action and maintenance. The cycle also provides for relapse.

Holistic Approach

It is evident that a needs-led service is required in relation to the matter of substance misuse however the concept of need and its assessment is a complex issue. Users of services such as LDTF projects require multi-disciplinary input to deal with their complex needs. A holistic approach meets these requirements. Holistic methods involve in-depth assessment carried out collaboratively by the project worker with the service user, his family and the community at large. This offers service users the opportunity to self-assess their difficulties. Personal, family and social circumstances are explored along with strengths and aspirations, cultural and religious aspects, physical health problems, employment status, relationship strengths and weaknesses, functioning, and alcohol, drug and substance use and misuse issues (Golightley, 2009). Holistic assessment affords project workers the opportunity to get to know the service user and understand their socio-cultural environment. It also guides project workers in creating a person centred care plan to meet identified needs. The assessment is shared between project worker, service user and often family, partners and friends.

Conclusion

The Gurranabraher/Churchfield project's response to drugs issues among young people is sophisticated and creative encompassing many methods and models of practice. It is a needs driven community-based response which is pragmatic, holistic and comprehensive in nature. There are a multitude

of complex societal factors which contribute to substance misuse situations which must be taken in to account to provide an integrated response. The project takes in to account the social perspectives of substance use and does not limit itself to prescribed operational procedures.
There is a danger in constructing 'drugs' as an isolated social issue. Davenport-Hines (2002) argues that relying solely on a prohibitionist approach based on a medicalised model is ineffective and, at times, counterproductive in dealing with drugs issues and young people. It has become clear that no single approach or ideology can claim universal truth when dealing with the complexities associated with youth drugs work. Our investigation into the LDTF project has shown that through utilising various theoretically informed models and methods, a creative response to drug issues can be delivered effectively in a community setting. Flexible and multitudinous varieties of approaches have developed since the instigation of DTF projects which has allowed methods from the harm reduction paradigm to become well established. Project workers' personal connections to the locality and relationships with service users make an effective, person centred, holistic approach possible.

In marginalised communities such as Gurranabraher and Churchfield, it is those who suffer from cumulative disadvantages that comprise the overwhelming majority of service users in difficulties (O'Mahoney, 2008). The project is effective since it employs creative strategies and is not constrained by conventional methods. A prohibitionist medicalised approach, based on flawed assumptions surrounding drug use, has only served to further marginalise young people with substance use issues. However, the pragmatic response of the Gurranabraher/Churchfield

project, which is guided by social-scientific theory and integrated by highly skilled workers, is dedicated to *understanding* the contributing factors to substance misuse issues and young people.

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Appendix 5; Youth Work Ireland Cork Gurranabraher-Churchfield Drugs Outreach Project Staff

Youth Work Ireland Cork

Mr. David O'Donovan	Director of Services + Manager of Gurranabraher-Churchfield Drugs Outreach Project
Ms. Eleanor O'Sullivan	Gurranabraher SPY Project Coordinator

Gurranabraher-Churchfield Drugs Outreach Project

Mr. Pat O'Connell	Fulltime Drugs Youth Worker, he has been employed with YWIC in Gurranabraher-Churchfield for over 20 years.
Ms. Theresa Spillane	Youth and Family Worker, part time, she serves as project representative on the YWIC board of directors
Mr. John Lane	Psychotherapist, voluntary.
Mr. Liam O'Mahoney	Arbour House counsellor, works approximately 5 hours per week with the project.

Appendix 6; Service User Case History, Ann

Ann is aged between 26 and 28 years of age. She grew up in the Churchfield area and has four siblings; three brothers and a sister, all four use heroin. Her mother and father separated when Ann was 16, her father has never had a job and has a history of drinking and cannabis use. Her mother holds an unskilled position and is not a regular drug user.

Ann left school when she was 16; she has never had a job. She has had two significant relationships, both with heavy drug users. She is married and has a pattern of arguing and fighting with her husband, splitting up, and then making up. They have a flat in the Luke's Cross area of the city; when they split up Ann leaves the flat and seeks help from 'Diamond'. Although her flat is in a different area of the city she considers herself to live in Churchfield.

Ann has one child, this child is in foster care with a family member; she made contact with a GCDOP worker when she became pregnant again. Ann became aware of the project through 'Diamond', an intervention that provides accommodation and other supports to women in distress. The GCDOP run a group in 'Diamond' on a weekly basis. Ann did not engage during a group session (she was not a group member); instead she approached a (female) GCDOP worker on the street and made contact there. The worker took Ann into a cafe and Ann told her story to this worker; she wants to quit using as she does not want to lose her unborn child to her drug use or to the childcare system.

Ann has been using various psychoactive substances since she was 16, starting with alcohol and cannabis. Ann is as

polydrug user, from age 20 onwards her use changed to heroin, cocaine and prescription drugs. She had difficulty accepting that prescription drugs were drugs, with the project's assistance she has now switched to a new GP. She no longer uses alcohol. Ann needs approximately 1,000 euro a week to pay for heroin; she usually smokes it but does occasionally inject. She funds her use through prostitution; she works six nights a week and has a number of regular clients with whom she feels safe. She never had a health/sexually transmitted infection check prior to engaging with the project, and was unaware of the various services that exist in this regard.
Ann doesn't work on the day that she collects her unemployment benefit.

The worker involved describes Ann as both a 'smart girl' and a tragic case; Ann's sister has a similar biography and current life situation.

Appendix 7; 'High Level' Service User Statistics 2010

Although this study relies on qualitative data it is useful to briefly review the numbers of people with high levels of need who have accessed the services. From January to October 2010 the project has worked with a total of 69 drug users who can be characterised as having a high level of intervention; 33 of these people were in various groups and 36 are/were individual service users. Additionally, although not problematic drug users themselves, the parents and the concerned persons groups represent another category of service user. These overall figures do not include casual enquiries, work conducted from a preventative perspective or activities such as the occasional session with groups such as the skateboarders. The terms of age and gender the figures break down as follows;

Table 1; Current (Oct. 2010) Service Users; Groups

Group	M	F	Total	Age Range	Substances Used
Friday Aftercare	7	2	9	17 – 32	Heroin, Alcohol, Polydrug
Emerald Girls	N/A	8	8	16 – 21	Experimental Use
Diamond Women	N/A	4	4	22 – 30	Heroin (smoked, occasional injection)
Brief Intervention	11	1	12	17 – 26	Alcohol, Cannabis (variants), Cocaine, Heroin
Totals	18	15	**33**	17 - 32	

Note; There is also a concerned persons group of 4 people and a parents group of 5 people.

The project runs 6 groups per week, groups usually run for approximately one hour.

Table 2; Current (Oct. 2010) Service Users; Individuals

Age	M	F	Totals
17	1	1	2
23	2		2
27	1		1
32	1		1
33	1		1
34	2		2
Totals	**8**	**1**	**9**

Note; Most individuals get one or two 'one to one' sessions per week; however, one individual has been receiving two or three sessions per week for an extended period. Sessions are typically one hour in length.

Table 3; January to September 2010; Former Service Users

Age	16	17	18	19	20	21	24	26	27	30	36	
M	0	1	0	1	1	2	3	2	0	1	3	**14**
F	1	1	3	3	1	1	1	1	1	0	0	**13**
Totals	1	2	3	4	2	3	4	3	1	1	3	**27**

Note; the age profile is concentrated in the young adult (17-25) age bracket; typically, younger individuals don't perceive their drug use as a problem. The project workers believe that a significant proportion of these former service users will re-engage on an ongoing basis.

Table 4; January to September 2010; Former Service Users Whereabouts/Situations

Situation	M	F	Totals
Clean	6	2	8
Relapsed/Using	2	3	5
Prison	1	2	3
Treatment	2	1	3
Homeless	0	1	1
Pregnant	N/A	3	3
Unknown	2	5	7
Methadone Maintenance	0	1	1

Note; some individuals are in two or more categories. The current drug use status of some individuals is unknown to the project.

Table 5; Inward Referrals (January to October 2010)

The vast majority of service users learn about the project through word of mouth. A limited number are however referred in from other agencies.

Gardai	4
Social Services	2
Other Drug and/or Alcohol Services	3
Total Inward Referral	**9**

High Level Intervention Service Users, Totals; Male; 40
Female; 29 Overall Total; 69

Endnotes

[i] Roberts makes the point that perceived reality is different from actual reality in that the general view of drugs issues has been severely misrepresented;

> *"If you read the newspapers, you might get the impression that young people's drug use is spiralling out of control, and that illegal drug use is an everyday part of their lives. In reality, most young people don't use drugs, only small numbers take the most harmful drugs, and only a minority of this group develop serious drug problems. The trends appear to be heading in broadly the right direction too. Fewer young people appear to be using drugs now than in the mid-1990s.The picture on alcohol use is less clear, and perhaps less positive"* (p.6)

[ii] The World Health Organisation's (WHO) international Classification of Diseases considerer's addiction as a diagnosis when three or more of the following symptoms are present;

1. A strong desire or compulsion to take the drug

2. Difficulties in controlling substance taking behaviour in terms of onset, termination or levels of use
3. A physiological withdrawal state when substance use ceases or is reduced as evidenced by the characteristic symptoms for withdrawal from the particular substance
4. Evidence of tolerance, such that increased doses of the psychoactive substance are required to achieve effects
5. Progressive neglect of alternative pleasures or pursuits because of substance use; increased time devoted to use or to recovery from effects
6. Persistent with use despite clear evidence of harmful consequences
   (World Health Organisation).

Note that only points 3 and 4 are biologically measurable. Tolerance and withdrawal are the two criteria that can be employed.
Point one is a self reflective criteria (cravings), a case of addiction can be diagnosed with no biological evidence. Klein argues that;

> "*An addict is therefore someone so declared by a specialist on the basis of the client's subjective assessment*"
> (Klein, 2008)

Given the multiple variables involved it is extremely difficult to accurately gauge the general populations opinion on drug issues at any one time.

> *"Respondents in Ireland were among the least likely to see the clampdown on drug dealers and traffickers as effective. Conversely, Irish respondents were among the most likely to believe that the treatment and rehabilitation of drug users was an effective way to deal with society's drug problems. Irish respondents (22%), along with those in the UK and the Netherlands, most favoured the legalisation of drugs"* (Reitox, 2008, p.23).

[iii] Treatment pillar aims and objectives of the National Drugs Strategy 2009-2016.

Aims;

- *To enable people with drug misuse problems to access treatment and other supports and to re - integrate into society;*
- *To reduce the risk behaviour associated with drug misuse; and*
- *To reduce the harm caused by drug misuse to individuals, families and communities.*

Objectives;

- *To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well- being, with the ultimate aim of leading a drug - free lifestyle; and*
- *To minimise the harm to those who continue to engage in drug – taking activities that put them at risk.*

Quality Youthwork Services

UCC

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