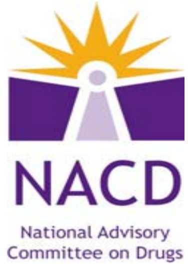
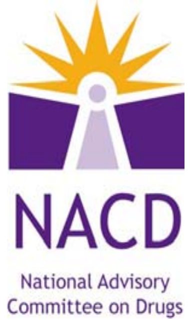


NACD Rehabilitation A Collection of Papers

NACD, Shelbourne House, Shelbourne Road, Ballsbridge, Dublin 4.

www.nacd.ie



National Advisory Committee on Drugs

Key Issues relating to best practice in drug rehabilitation

Dr Aileen O'Gorman
Research Officer
NACD

National Advisory Committee on Drugs

NACD

- Established July 2000
- Committee - 18 members representing statutory, voluntary and community sectors
- Role – To advise Government in relation to the prevalence, prevention, consequences and treatment of problem drug use, based on analysis and interpretation of research findings.

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Methodology

- Request by Drug Strategy Unit to provide briefing paper to Working Group on rehabilitation
- Discussions within Treatment/Rehabilitation sub-committee of NACD
- Review of literature; review of rehabilitation project evaluations in Ireland and EU; review of report on multi-agency partnerships in key worker services (all in NACD Reference Document)
- Production of Key Issues paper.

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Background

- Problem drug use – a chronic, recurring condition
- Context: ill-health, poverty, unemployment, educational disadvantage, housing problems, fractured family and community relationships, criminal justice problems etc
- Treatment services – overstretched
- Demand for treatment elastic – socio-economic conditions continue and drugs markets grow
- Little progression on from treatment – need for rehabilitation strategy to address broader health, social, housing, educational, vocational, family and community needs.

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Rehabilitation: definition

(see section 1.1in Key Issues paper)

- A holistic approach - encompasses treatment and harm reduction as well as broader health and social needs
- provides a continuum of care
- requires an integrated response - inter-agency co-operation key.
- is client-centred - responds to the self-identified needs of the problem drug user.

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Rehabilitation: model

Drug User

Key worker

Assessment

Care Plan

Services

Key components of rehabilitation

- Support and advocacy
- Health promotion
- Personal development
- Understanding drug use
- Education
- Employment training
- Social and recreational activities
- Family support
- Community development.

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Rehabilitation: Challenges

- Resources – personnel and services
- Service provision in regions
- Conflicting ideological perspectives (e.g. on understanding of drug problem and goal of treatment/rehabilitation)
- Inclusive services; accommodating diversity
- Interagency co-operation - sharing of information
- Concurrent polydrug use
- Housing needs of drug users

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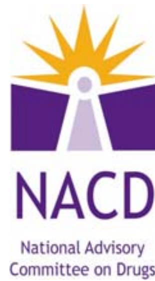
What's needed

- resources
- training and employment structures for key workers;
- protocols to facilitate the level of inter-agency co-operation and information sharing needed
- standard assessment instruments
- templates for care plans;
- drug related skills training and policy development for mainstream services.



Key issues relating to best practice in drug rehabilitation[1]

Preface

This paper has been prepared by the National Advisory Committee on Drugs (NACD) to inform the Working Group on Rehabilitation established by the Drug Strategy Unit. The paper is based on a series of discussions within the NACD's Treatment /Rehabilitation sub-committee and the NACD main committee; and a review of the literature evidence as to what constitutes best practice in drug rehabilitation (see NACD Drug Rehabilitation Reference Document).

1. Rehabilitation – what is it and why is it needed

1.1 Drug rehabilitation is a holistic approach which provides a 'continuum of care' to problem drug users enabling them to address their (drug use, health, social, housing, educational, and/or vocational) needs as is most appropriate for them; and which is aimed at maximising their quality of life, and that of their families and communities; and enabling their re-integration into their community. In this sense, drug rehabilitation encompasses interventions aimed at stopping, stabilising and/or reducing the harm associated with a person's drug use as well as addressing a person's broader health and social needs.

1.2 In dealing with the individual in this holistic way, rehabilitation recognises that problem drug use exacerbates, and is exacerbated by, other difficulties in a person's life such as ill-health, poverty, unemployment, educational disadvantage, housing problems, fractured family and community relationships, criminal justice problems etc. Consequently, curtailing and/or controlling drug use is just one aspect of rehabilitation; an integrated response, involving a high level of inter-agency co-operation between statutory and

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[1] From the Latin *habilitas* meaning 'to make able'.

community/voluntary sectors who provide services to drug users is required to meet their needs.

1.3 Problem drug use is a chronic, often recurring, condition. As a result, rehabilitation is best understood as a process which supports and encourages drug users at each stage of their drug using career (from those whose drug problem is severe and chaotic, to those who have stabilised, recovered or relapsed), and at each stage of their cycle of behavioural change – pre-contemplation, contemplation, action, maintenance, and relapse.

1.4 To date, there are 7,681 clients receiving methadone treatment in the state (Central Treatment List 31/06/05). In all, there were approximately 8,500 cases treated for problem drug use[2] in 2002 (most recent data available from NDTRS); 6,248 of these cases were living in the HSE Eastern area – 85% of whom had been previously treated, and the main problem drug reported was opiates (95% of cases); a further 2,397 cases were treated in the seven HSE areas in the regions – 38% of these cases had been previously treated, and the main problem drug reported was cannabis (57% of cases). The demand for drug treatment has so far proved to be elastic, and many services report being overstretched as incidence rates continue to rise. Without a rehabilitation strategy to address drug users' broader needs, many will continue to remain in treatment indefinitely or continue to move in and out of treatment services.

1.5 It is important to note that not all drug users will require or wish to avail of rehabilitation services; the crucial issue is that these services are client-centred and respond to the self-identified needs of drug users.

2. Best practice in Rehabilitation

2.1 It would be neither feasible nor desirable to develop a standard model of rehabilitation - one model will not fit all. Socio-demographic data on clients in treatment for problem drug use provided by the NDTRS[3] indicate that different drug users have different drug using histories, different life experiences, and consequently, different rehabilitation needs.

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[2] Treatment options included in this reporting system include medication (detoxification, methadone reduction and substitution programmes), addiction counselling, group therapy, psychotherapy and/or life skills training. Treatment is provided in both residential and non-residential settings.

[3] Of the 2397 cases in treatment outside the Eastern regional HSE in 2002, over three-quarters were male (80%); average (median) age was 23 years, range 16-42; well over half (59%) were living with their parents/family; under a quarter (18%) were early school leavers, 14% were still in school; and almost three quarters (69%) were not employed. Within the Eastern Regional HSE area, the profile of the 6191 cases in treatment in 2002 showed

2.2 The evidence suggests that client-centred care plans - i.e. plans which are appropriate for each individual and based on an assessment of their needs; which have negotiated and agreed goals, revised and updated as necessary; and which are supported by a key worker - would be is an optimum strategy.

2.3 Rehabilitation care plans should address the needs of the whole person, including measures to address drug use along with personal and social development, adult education etc. In this way, care plans need to draw upon a range of different services in different settings, e.g. health care may be provided by a GP in a primary health care setting, educational training by a community college etc.

2.4 Standard drug rehabilitation assessment forms, for use at different stages in a person's drug using career, should form the basis for the development of care plans.

2.5 The process of drug rehabilitation should begin at the first point of help-seeking contact a drug user makes to a service. Each drug service should have at least one drug worker who is trained to conduct basic rehabilitation assessments; drug users requiring more intensive assessment e.g. a long-term care plan for a stabilised drug user may need to be referred to a key worker with specialist rehabilitation training.

2.6 The role of Key Workers would be to develop and monitor drug users' care plans. Where possible Key Workers should be employed in statutory and community drug services where the client base is large enough to maintain this. Otherwise, they should be allocated to work with a number of services and work in close partnership with the main drug service their clients are attending, for example taking part in team meetings, case meetings and be based in the service for a proportionate number of hours/days per week.

2.7 The rehabilitation programmes we reviewed had a broad range of goals, from programmes which emphasised drug free lifestyles and/or stabilised drug use and/or focused on improving the quality of life of their clients through improving health, family relationships, work opportunities etc. From our review, it is possible to identify some key components which, in conjunction with drug treatment (where needed), would form the

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that just over two-thirds (67%) were male; average (median) age was 27 years, range 19-41; over half (56%) were living with their parents/family; over a quarter (29%) were early school leavers, 13% were still in school; and over three quarters (77%) were not employed. There were some differences of those being treated for opiate related problems, namely higher rates of early school leaving and higher rates of unemployment.

basis of an integrated rehabilitation programme which drug users could access according to their needs:

- Support and advocacy – dealing with family support; housing/resettlement; social welfare; criminal justice issues, community re-integration etc - is likely to be a significant issue
- Health promotion – general well-being, diet, harm reduction, safe sex information etc.
- Personal Development - general life skills, social skills, communication skills. In particular family and community support services are likely to be central to progress
- Drug use – understanding addiction; motivational interviewing and peer advice to develop strategies for avoiding drug use, drug related harms and relapse; group therapy and one-to-one counselling etc.
- Education – using adult education practices to encourage social analysis, esteem raising etc. as well as literacy, numeracy, art, and vocational training
- Employment - Job search and interview skills; job preparation and placement
- Social and recreational activities – to provide an alternative to a drug using lifestyle and boost morale and confidence.

2.8 These programme components were seen to work best when they addressed the issue of diversity in terms of responding to the different needs of male and female, young and old, Travellers, homeless, and drug users from minority ethnic groups.

2.9 Community-based projects were seen to be valuable in terms of addressing the client's drug problems in the context in which it developed and placing an emphasis on a holistic approach involving family support and community development. They also had scope to be more flexible and client centred than the structured residential programmes. Evidence suggests that community-based projects are best served to facilitate the re-integration of the drug user into their community.

3. Challenges to implementation

3.1 The implementation of a national integrated rehabilitation strategy has substantial resource implications.

3.2 For drug users living in the regions and rural areas there is the added logistical problem of accessing the range of rehabilitation services they require when services and personnel are scattered across a wider geographical area.

3.3 The rehabilitation programmes currently available to drug users reflects a diverse range of ideological perspectives on drug use. It is important to acknowledge and accept that these differences exist and shape the nature of rehabilitation services. For example, for some rehabilitation services the primary goal is to be drug free; for others, reducing the harm associated with drug use is the main goal. In addition, some view addiction as a medical issue; while others view addiction as part of a broader set of social problems. These different perspectives need to be made explicit in discourses on drug rehabilitation because they have ongoing implications for the type and quality of care provided to drug users, not least in terms of hindering interagency co-operation and the sharing of information that is needed to develop holistic, shared-care plans for the individual.

3.4 To achieve best practice in the rehabilitation strategy proposed, a number of issues will need to be addressed:

i) the establishment of transparent training and employment structures for key workers – addressing issues of accredited training, inclusion in drug services; accountability etc;

ii) the development of protocols to facilitate the level of inter-agency co-operation and information sharing needed to implement shared care plans;

iii) the development of template assessment instruments for drug users at different stages of their drug using careers;

iv) the development of templates for individual rehabilitation care plans; and

v) the introduction of drug related skills training and policy development for mainstream services who provide rehabilitation programmes to drug users.

3.5 Many existing treatment and rehabilitation services have been dedicated to the treatment of opiate use; in the past few years cocaine use, polydrug use, and the misuse of alcohol and prescribed medication in conjunction with illicit drug use have posed challenges to the delivery of services. In the future, new drugs and new drug trends will undoubtedly arrive onto drug using scenes. It is important that services are developed to meet the diverse needs of a range of problem drug use.

3.6 Employment is just one aspect of a rehabilitation strategy. Community Employment schemes are not an end in themselves and there is a need to build in progression routes out of these into mainstream employment. This would require information campaigns and negotiation with Employers Associations, Trade Unions, Partnership companies etc. to reduce stigma and alleviate fears about employing recovered or stabilised drug users and/or persons with HIV/AIDS.

3.7 Lack of suitable housing is one of the main barriers to rehabilitation and was seen to impact negatively on the welfare and rehabilitation outcomes of drug users. Tackling this issue will also entail addressing the effects of current housing legislation, and planned legislation dealing with anti-social behaviour, on drug users. The development of sheltered accommodation facilities with a focus on preparing the drug user for independent living should be considered as part of this strategy response.

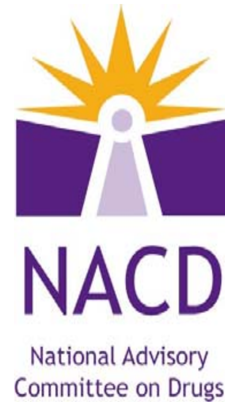
3.8 Best practice in rehabilitation requires the individual to be actively involved in the planning delivery and review of their care. In addition, service users should be involved in service planning and decision making. This level of client-centred care has not yet developed in Ireland.

3.9 Services need to be as inclusive as possible in terms of addressing drug users' needs at different stages of their drug career, providing culturally appropriate services, and developing equality and diversity policies which respect the class, gender, ethnicity, and sexual orientation of their clients.

3.10 The benefits gained from a residential rehabilitation programme with an emphasis on routine and structure were seen to be short-lived unless follow-up and post release support was made available and housing and accommodation needs were met. This issue is also applicable to drug users leaving prison. However, residential care as a crisis intervention with chaotic drug users who require a short-term spell of respite care is seen as key to the rehabilitation of this client group.

3.11 At an organisational level, clearly identified aims and objectives were seen to be required by services delivering rehabilitation projects, as was a shared vision among staff about the type of programme they were delivering. These were seen to be needed to be revised and updated frequently as many projects evolved and developed in response to client needs and to what worked best. In this sense it would be good practice for rehabilitation programmes to have an ongoing evaluation built in, so as to assess their impact and adapt as necessary. As organisations extended, management training, and training in programme development may also be beneficial for the organisation. Service user involvement in programme planning was also seen to be best practice.

14 September 2005



NACD Drug Rehabilitation Reference Document

(Prepared by Una Molyneux and Martha Doyle)

This reference document includes the following sections:

Section One: Literature Review
Section Two: Drug Rehabilitation Services in Ireland: a review of project evaluations
Section Three: Drug Rehabilitation Services in Europe: a review of a sample of project evaluations
Section Four: Review of research report on "An exploration of different models of multi-agency partnerships in key worker services"

SECTION ONE

LITERATURE

REVIEW

Ms Martha Doyle

Section 1: Drug Rehabilitation – Literature Review

This review aimed to examine the concept of rehabilitation in its broadest context and assess:

- the aims and rationale of drug rehabilitation
- the models and definitions of drug rehabilitation in Ireland and internationally and
- the outcome and efficacy of different rehabilitation programmes and concepts.

In conducting the review, particular attention has been focused on the issues outlined in the National Drugs Strategy with regard to rehabilitation, such as the availability of rehabilitation options within health board areas; training and employment opportunities; and the potential of social economy initiatives and vocational training.

The material collected for this review is based on: a search of standard databases for published literature in the area of rehabilitation such as Psychlit, Social Citation Index and the National Documentation Database[1]; a comprehensive Internet search of international Government drug agencies; communication with Dr Donal McAnaney, Programme Director of Rehabilitation Studies at UCD; and additional information obtained from the National Drugs Strategy Team and NACD staff.

The report is broken down into the following categories;

- Definitions of rehabilitation
- Vocational rehabilitation
- Housing
- Psychosocial therapies
- Complementary therapies
- Residential rehabilitation
- Rehabilitation in the Irish context

[1] See Appendix for list of key search terms

Definitions of rehabilitation

Due to both the complex needs of drug users and the variety of theoretical approaches to treatment, a concise definition of rehabilitation is difficult to make. Some organisations view it as a distinct phase separate from treatment, while others view it as an integral part and process of treatment. According to the theoretical perspective of the organisation the definition of **treatment, rehabilitation, after-care, social reintegration, reintegration, vocational rehabilitation, and psycho-social rehabilitation** can take a different meaning, reflecting the overlap and interplay of the various perspectives of drug addiction.

United Nations Office on Drugs and Crime

The United Nations Office on Drugs and Crime has produced 3 useful documents entitled, 'Drug Abuse Treatment and Rehabilitation: A practical planning and Implementation Guide' (2003), 'Contemporary Drug Abuse Treatment: A Review of the Evidence Base' (2002) and 'Investing in Drug Abuse Treatment: A Discussion for Policy Makers' (2003).

The drug treatment and care process advocated by the UNODC consists of 3 stages, namely;

- Detoxification: stabilization phase of treatment
- Rehabilitation: Relapse prevention phase of treatment
- Aftercare[2]

While commenting on the difficulty of developing concise categorizations of treatment, the UNODC stress that no one treatment/rehabilitation programme will be effective for everyone. Rehabilitation as defined by the UNODC[3] is,

'the process of helping individuals to establish a state where they are physically, psychologically and socially capable of coping with the situations encountered, thus enabling them to take advantage of the same opportunities that are available to other people in the

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[2] Aftercare is defined as

'A period of less intensive treatment, after a client has completed the main programme....it may be limited to a month or substantially longer..........'the effectiveness of such services has not been subject to formal evaluation to date, but there is a general commitment to their value and availability.' (Drug Abuse Treatment and Rehabilitation, p. IV5)

[3] Measures to Reduce Illicit Demand for Drugs

same group in society.' (Cited by Murthy, Developing Community Drug Rehabilitation and Workplace Prevention Programmes, 2002, Report for ILO and UNOCD, Section 2.)

The rehabilitation or relapse prevention phase of treatment is oriented to the needs of persons who have either completed a formal detoxification or who have dependence but no formal withdrawal symptoms. Psychosocial and pharmacological interventions are involved in this phase of treatment. The importance of maintaining abstinence /stabilization is thus viewed as an integral aspect of the rehabilitation phase;

'Rehabilitation is appropriate for patients who are no longer suffering from acute physiological or emotional effects of recent substance use and who need behavioural change strategies to regain control of their urges to use substances. A practical goal of this stage is to prevent a return to active drug use that would require re- detoxification/stabilisation, either through sustaining total abstinence from all drugs and alcohol or through substitution treatment; and to assist the patient in regaining or attaining improved personal health and social function, both as a secondary part of the rehabilitation function and because these improvements in lifestyle are important for maintaining sustained control over substance use.'(p23 Investing in Drug Abuse Treatment: A Discussion Paper for Policy Makers).

However, the UNCOD state that abstinence is not necessarily a prerequisite of rehabilitation, they point to programmes in Australia, Western Europe and North America where patients are maintained on a medication that is designated to block the effects of the abused drugs thus preventing the re-emergence of drug use.

The European Monitoring Centre for Drugs and Drug Addiction

The EMCDDA[4] use the term social reintegration as an umbrella term for social rehabilitation and reintegration. They state that most countries have no explicit definition or description of social reintegration. Unlike treatment, social reintegration does not necessarily include a medical or psycho-social component. Social reintegration is viewed in its broadest context, and can be linked with general interventions and services which are accessible to the general population. Reference is made to the interconnection between social exclusion, problem drug use and reintegration. Rehabilitation is viewed as something which should be offered to both former and current drug users and can be defined as;

[4] **EMCDDA – 2003** – Social Reintegration in the EU plus Norway

'any integrative efforts for (former) drug users in the community' (p2).

After conducting a review of reintegration projects in Europe, the EMCDDA grouped social reintegration interventions into three categories;

- Training, education and development of skills
- Employment
- Housing
- In addition, some countries also provide debt counselling and supported living.

Taking a similar viewpoint to the UNCOD, abstinence is not an essential precondition of rehabilitation, taking a somewhat different perspective to the UNOCD, however, the EMCDDA views rehabilitation as something which can take place during, or prior to, or after treatment:

'Social reintegration is not necessarily perceived to be neither last step in a complete treatment process nor a post-treatment intervention, but rather a separate and independent intervention with its own goals and means which can be for both former and current problem drug users. This means that social reintegration does not necessarily take place after treatment but can take place irrespective of or prior to treatment - [rehabilitation also covers] the entire spectrum of clients as a target group, ranging from well-functioning 'clean' former addicts to very deprived street addicts.' (p.4)

The EMCDDA stress that consideration of the evaluation of the effectiveness of rehabilitation is important. Caution is recommended that evaluations of social reintegration interventions do not specifically look at indicators such as consumption patterns and improvement of physical and mental health but also focus on the final objective which is integration of the former drug user into society.

Definitions of Rehabilitation from other Organisations

The **Scottish Executive** views rehabilitation as a broad concept – offering a myriad of supports. Rehabilitation as a service is delivered to current, former and stabilised drug users:

'the definition of 'treatment' or 'rehabilitation' can vary from a very brief, 'harm reduction' intervention – such as providing a needle exchange service or information – to an intensive residential programme lasting many months. The services will also see clients with a wide range of needs, from those whose drug problems remain severe and chaotic to those who are stabilised or recovered. (p.27, Moving On: Education, training and employment for recovering drug users, 2001)'

World Health Organisation

According to the WHO Lexicon of Alcohol and Drug Terms,
'rehabilitation' is the defined process by which an individual with a drug related problem achieves an optimal state of health, psychological functioning and social well being .....it encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half way house, vocational training and work experience. There is an expectation of social reintegration into the wider community.'[5]

Vocational Rehabilitation

The **International Labour Organisation** recognises the importance of vocational rehabilitation for substance misusers. The ILO points to the need to educate employers and workers groups on substance abuse issues and engage community groups with employment links. They classify vocational rehabilitation as;
'training/retraining the recovering addict for suitable and viable employment, selective placement, on job assistance and follow-up, sensitising key employers and workers' groups to addiction as a safety and health problem and forging relationships with community groups that have a business and employment orientation.' (Cited by Murthy, Developing Community Drug Rehabilitation and Workplace Prevention Programmes, 2002, Report for ILO and UNOCD, Section 2.)

Where open employment is not a viable option, alternatives such as self-employment, supported work, apprenticeship, and co-operatives are recommended.

[5] Drug Abuse Treatment and Rehabilitation (2003)– A practical planning and implementation guide. United Nations Office on Drugs and Crime.

The Council of Europe has compiled a useful report entitled 'Vocational Rehabilitation for Drug Users in Europe' (2000). According to this report:

'*Vocational rehabilitation is a reasonable and effective measure enabling drug using or drug-dependent persons to participate in regular occupation and in mainstream society. Vocational rehabilitation programmes include assessment of individual vocational needs, counselling, skills training and job placement.' (p19)*

According to their literature review, there are three types of vocational rehabilitation;

- **Supported work programmes**
  These involve job training, general skills training and sometimes job-site intervention. They intend to give drug dependent persons a daily structure and prepare them for regular work.
- **Skill-building programmes**
  They provide a range of activities such as skills training, problem-solving training and coping training in order to improve the social competence of drug dependent persons. They are designed to increase success in obtaining and maintaining employment.
- **Job placement programmes**
  Their emphasis is on job-seeking, job-holding skills and counselling.

The Council of Europe report, while stipulating that there are convincing arguments about the importance of employment in addiction treatment, also states that the existing literature on evaluation research in this area is 'rather poor/moderate'. It states that no systematic, comparative evaluation research on vocational rehabilitation programmes exists in Europe. However, the Council does view employment as an indicator of successful treatment, a predictor for staying in treatment and a reasonable means for reintegration into society.

Recommendations for further research in the area of vocational rehabilitation as put forward by the Council of Europe (2000) report include;

- A system of standards and indication criteria developed for vocational rehabilitation programmes. They state that more detailed information about which type of programme fits best depending on the specific conditions and needs of drug-dependent person is required.
- A systematic and standardised evaluation of vocational rehabilitation programmes is needed in order to get better comparative results according to programme outcomes.

- Further research is needed in the area of employment of female clients and on the specific situation of clients with dual diagnosis.

The Scottish Executive provides a comprehensive over-view on the area of employment and drug misusers in 'Moving On: Education, training and employment for recovering drug users' (2001). The report includes the results of a qualitative study of the views and experiences of agencies, services providers, services users and employers; a mapping exercise and a comprehensive review of the literature. The report can be viewed as a blueprint or toolkit for services providers working in the area of drug rehabilitation. It outlines in a concise manner issues relating to barriers to education, training and employment.

The results of their literature review point to the effectiveness of vocational services in conjunction with treatment, to improve both employment rates and earnings of former substance misusers. Caution is raised with respect of reviewed studies which look at employment as the sole outcome measure – they maintain that few studies examine the effect of employment and training support during treatment on client outcomes.

A subsequent update of the 2001 Moving On Report was made in 2004. This follow-up report focuses more specifically on the concept of employability and the needs of employers and local labour market demands. In a similar style as the first Moving On report the review offers comprehensive best practice suggestions relating to employment of drug users. Issues addressed include barriers to employment, job readiness, programme design and ways to enhance employability provision by developing collaborative partnerships with employers.

Another comprehensive review of drug rehabilitation and employment was conducted by South, Akhtar, Nightingale and Stewart (2001). Their literature review focused on evidence based research conducted in the area of rehabilitation and treatment, schemes offering education and training, employment or volunteering placements for drug users since 1980. They conclude that the literature supports the view that meaningful employment has therapeutic value; protects against social exclusion; furthers reintegration; and that employment is one of several factors which help to prevent a return to problem drug use and criminality. Similar to the Council of Europe report, the authors refer to the scarcity of well-designed initiatives for women.

The authors recommend training of employment staff, citing a study which revealed that after receiving basic training on identifying and managing clients with drug and alcohol problems, two–thirds of the employment staff declared themselves more willing to participate in interventions with problem drug users. The report stresses the importance of recognising the need for rehabilitation, to provide both clinical and non clinical supports, and that drug treatment and rehabilitation from the outset need to be linked to the wider goal of social re-integration.

The National Institute on Drug Abuse website also provides useful practical guidelines on the delivery of vocational counselling, highlighting the importance of goal setting, and the achievement of long-term and short-term goals. Additional counselling/training courses which they advocate under the headings of lifestyle change components include time management, social/recreational counselling, problem solving, social-skills training and assertiveness training.

Housing

The British Home Office has developed a comprehensive strategy and policy guide entitled 'Housing support options for people who misuse substances' (2005). The importance of housing as an effective reintegration tool is stressed;

'Appropriate and sustainable housing is a foundation for successful rehabilitation for substance misusers, especially drug users and offenders. Appropriate housing provision and housing support is crucial to sustaining employment, drug treatment, family support and finances, and is a major resettlement need for those leaving prison and residential rehabilitation in particular.' (Executive Summary, p.1)

Methods they suggest which could reduce barriers to housing for substance misusers include;

- Arrangement for payment in arrears
- Certified courses for substance users to show they have learned new coping mechanisms
- Rent deposit and rent guarantee schemes
- Drug awareness training for landlords and generic housing workers
- Risk assessment protocols for landlords and tenants.

While not offering an overview on housing and drug rehabilitation it does outline in detail the key factors which need to be considered with respect to this subject matter. An

extensive mapping exercise to estimate the housing needs of substance misusers is put forward. Housing related issues pertinent to some substance misuses are highlighted; these include disputes with neighbours, debt, lack of experience in managing a home and unwanted guests (eg drug-using peers and dealers operating in-house).

The report makes a distinction between people who may require appropriate housing and ongoing housing-related support and those who require drug specific supported housing services. Those who require the former include;

- People living in areas of high social deprivation
- People who are homeless or at risk of homelessness
- People with mental health problems
- People involved with the criminal justice system
- Young people who have been looked after by local authorities.

Persons categorised as more likely to require drug specific supported housing services include;

- People released from prison, especially those who were involved in drugs or drug treatment in prison
- Offenders on community sentences
- People currently engaged in drug treatment
- Former drug users, especially those leaving residential rehabilitation.

Another Home Office report which investigated the role of local authority housing in the care and rehabilitation of drug and alcohol users was conducted in the London Borough of Lambeth (1999). The sample consisted of 166 tenants who had secured housing by the Lambeth Housing Service (LHS), those who were 'homeless at home' or those who were in LHS temporary accommodation. Service providers were also interviewed for the research. The report concluded that for many clients securing housing has enabled them to remain abstinent or to reduce drug/alcohol consumption; it has motivated them to tackle other areas of their lives; and has contributed to the prevention of substance misuse by proving a material foundation for developing a better quality of life. The importance of rehabilitation with respect to housing was alluded to, with interviewees who had come through residential rehabilitation centres saying they would have welcomed more formal guidance on the process of application for housing, benefits, budgeting; decorating, home maintenance and buying of furniture and furnishing.

Complementary Therapies

The NHS report on 'Models of Care' (2002) evaluates the evidence base of complementary therapies. They conclude evaluations are inconclusive and contradictory, they cite the Effectiveness Review (Task Force to Review Services for Drug Misusers, 1996),

'Most of the reports [on the use of complementary therapies in drug treatment] are fairly positive but there are almost no data to support claims of treatment effectiveness. It is difficult to subtract out the general effect of care and attention to isolate the impact of the specific intervention. These therapies do apparently attract some drug misusers, eg. cocaine misusers, into treatment (p94)'.

Similarly a US government expert panel (National Institute of Health, 1997) stated that the evidence for acupuncture in addiction was less convincing than in other sectors, but promising enough to support its use within a comprehensive management programme.

A majority of the research focuses on the use of auricular or other acupuncture, particularly with cocaine users. Some research has indicated the positive impact of auricular acupuncture for drug misusers, while other research has found no advantages attributable to auricular acupuncture.

The National Treatment Agency for Substance Misuse[6] takes a favourable view on complementary therapies, in light of research which indicates it may enhance client retention and treatment compliance.

A technical report reviewing the efficacy of acupuncture for the treatment of substance abuse following the proceedings of a convened meeting on the issue by the National Institute of Drug Abuse (1991) may be a useful resource to obtain more information on this issue if required.

Psychosocial therapies

When conducting the literature search on psychosocial interventions and rehabilitation, little information was retrieved. An explanation for this may be that psychosocial interventions are generally categorised under the heading of treatment rather than rehabilitation.

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[6] In 'Models of Care for the treatment of drug misuse'

Literature retrieved seemed to focus more on counselling and psychosocial therapies in relation to maintaining/achieving abstinence/ stabilisation.

The National Treatment Agency for Substance Misuse refers to the importance of psychosocial therapies in relation to the treatment of cocaine and crack cocaine dependence. They purport that the evidence of the effectiveness for social and psychological therapies is far more substantial than for pharmaceutical therapies. Counselling approaches they elaborate upon include counselling, cognitive-behavioural therapies and group therapies. The importance of group support as an aftercare resource as a consequence of group therapy is mentioned. Rewards/punishment based therapies based on contingency management is more widely used in the US. The report states that best results are attained when rewards and punishments are immediate, frequent and achievable.

Psychosocial evidence based treatment interventions as detailed by the ATTC[7] include

- Cognitive behavioural intervention
- Behavioural couples therapy
- Family therapy
- Community reinforcement approach
- Contingency management
- The Matrix model
- Motivational interviewing/enhancement
- Solution focused brief therapy
- Supportive expressive therapy
- Twelve–step facilitation.

A review by the United Nations Office on Drugs and Crime[8] concluded that there is a scarcity of controlled research studies which indicates the effectiveness of;

- Alcohol/drug education sessions
- General group therapy sessions, especially 'confrontation' sessions
- Acupuncture sessions
- Patient relaxation techniques.

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[7] The Addiction Technology Transfer Center Network

[8] United Nations Office on Drugs and Crime – Investigating in Drug Abuse Treatment a Guide for Policy Makers (2003)

Residential Rehabilitation

The treatment philosophy, structure and intensity of residential rehabilitation services vary. According to Merchants Quay Integra project and the Scottish Executive there are tyree broad types of residential rehabilitation;

- Therapeutic communities
- 12 step programmes based on the Minnesota Model of addiction recovery treatment
- Faith-based Christian programmes

The understanding of Therapeutic Communities does not seem to be consistent in the literature. The Merchants Quay Intergra report classifies St Francis Farm Tullow, as a Therapeutic Community stating,

'Therapeutic Communities place an emphasis on respect for self and others, group therapy and peer support'. (p13)

The Scottish Executive defines Therapeutic Communities as,

'emphasising social learning, behavioural and cognitive behavioural approaches to achieving a healthy pro-social lifestyle characterised by abstinence. Therapeutic Communities promote change by developing self worth and personal responsibility, challenging individual attitudes and behaviour and encouraging the development of life and social skills through engagement in daily work and activity routines.' (Residential detoxification and rehabilitation services for drug users: A review, p7).

However, Therapeutic Communities as defined by the National Institute of Drug Abuse, takes on a somewhat different meaning and suggests more of a structured regimented format;

'[Therapeutic Communities] are residential programs with planned lengths of stay of 6-12 months. TCs focus on the 'resocialization' of the individual and use the program's entire 'community', including other residents, staff and the social context, as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibly and socially productive lives. Treatment is highly structured and can at times be confrontational, with activities designed to help residents examine damaging beliefs, self-concepts, and patterns of behaviour and to adopt new more harmonious and constructive ways to interact with others. Many TCs are quite comprehensive and can include employment training and other support services on site' (NIDA website, http://wwwdrugabuse.gov/PODAT/PODAT8.html).

Similarly, the work of Rawling and Yates (2001) on 'Therapeutic Communities for the Treatment of Drug Users', describes a rigid philosophy, with explicit rules and regulations. However, they do state that every Therapeutic Community differs in significant aspects. Fundamental principles of the TC which are common, are that

- every therapeutic community strives towards integration into the larger society
- every therapeutic community offers its residents a sufficiently long stay in treatment
- both staff and residents are open to challenge and to questions
- ex-addicts are of significant importance as role models
- staff regularly review their raison d'etre.

While the National Treatment Agency for Substance Misuse[9] cites their effectiveness in US studies, the Canadian Department of Health are sceptical of their value, citing the work of Landry (1995) who reported that although those who completed the required period of residence (one year or more) tended to do well after leaving, dropout rates tended to be very high (up to 90%). They also describe how many of the Therapeutic Communities are rather rigidly run and have a militaristic culture that relies on the use of confrontation.

The Scottish Executive – 'Residential detoxification and rehabilitation services for drug users: A review', includes a description of the aims of residential detoxification and rehabilitation services, a summary of the evidence on their effectiveness and a mapping of these services in Scotland. It identifies the inherent difficulties of comparing the effectiveness of residential services with community services. Differences between the two which make comparisons problematic included,

- The difference of immediate aims and duration of residential and community treatments
- The different types of interventions provided by community and residential programmes
- The different characteristics of clients entering community services as compared to those entering residential services.

Four factors found to influence the effectiveness of residential programmes were;

- Time in treatment
- Retention in treatment
- Client characteristic
- Provision of aftercare.

[9] In 'Models of Care for the treatment of drug misuse.' (2002)

The researchers deduce that residential detoxification and rehabilitation are effective in the treatment of drug misuse. However, they stipulate that residential rehabilitation must be viewed as a first step only, that it should be of at least three months duration, and that client retention and aftercare are of vital importance. The report suggests that residential treatment may not be the appropriate treatment for all drug users. Further research is recommended to investigate why more than approximately half the clients who enter rehabilitation leave; when residential as opposed to community treatment may be the preferred mode of treatment; models of good practice with respect to pathways into and out of residential rehabilitation; and factors that help to sustain the benefits achieved.

The Department of Health, Canada also questions the universal effectiveness of residential rehabilitation. They have produced a best practice guide on the treatment and rehabilitation of young people with substance use problems (2001). After reviewing nine major studies examining the impact of residential versus day treatment, results were not conclusive. They cite Spooner (1996) who states that the effectiveness of residential treatment is unconvincing, except in the case for clients who are homeless or for whom the usual environment is so conducive to substance use that a form of residential care is appropriate.

The UK's Department of Health, National Treatment Agency for Substance Misuse produced a guide, 'Models of care for the treatment of drug misusers' (2001). In this report the effectiveness of residential rehabilitation is reviewed. They conclude that only a small number of randomised controlled trials have been conducted in the UK. The studies they reviewed indicated that residential rehabilitation was found to be effective with respect to abstinence and criminal activity. They draw attention to the fact that duration of time in residential rehabilitation may have confounding effects on the effectiveness of treatment. Taking a similar viewpoint as the Scottish Executive, three months was viewed as the critical period or recommended minimum duration of residential treatment. However, they do cite a study by Simpson *et al* (1999) which found that shorter-term and less intensive treatments appear to be adequate for most of the less problematic substance users.

Rehabilitation in the Irish Context

Rehabilitation General – Ireland

In the EMCDDAs (2003), 'Social reintegration in the EU plus Norway' an attempt is made to classify the concepts of social reintegration in Ireland. After conducting a review of the 'Directory of alcohol, drug and related services in the Republic of Ireland', social reintegration initiatives were classified into three categories;

- Halfway houses
- Aftercare
- Employment programmes.

According to this report the target group of such reintegration initiatives have in the main been with former drug users, with few reintegration programmes catering for current drug users.

According to the report to the EMCDDA by the 'Reitox National Focal Point – Ireland Drug Situation 2002', reintegration interventions for former drug users in Ireland are predominantly classified under the headings of

- education
- training
- employment initiatives.

The report comments on the NAHB Rehabilitation/Integration Service – saying that the role of the RI workers is to assist individuals to develop rehabilitation/integration plans to meet their needs, drawing primarily on the existing services within the community. Among the agencies they work with are the Irish Congress of Trade Unions, the City of Dublin Vocational Education Committee, the Probation and Welfare Service, FAS, the Local Employment Service and the Youth Service.

Gerry McAleenan (2000) in his report to the Council of Europe on Vocational Rehabilitation, conducted a literature review; used the results of a survey of services- users (by Doran, 1999); conducted focus groups with drug service staff; and received submissions from the LDTF and community and voluntary sectors. He asserts that rehabilitation needs to:

- be comprehensive
- be holistic
- be multidisciplinary
- be delivered alongside a continuing of care
- offer an individual care plan

- offer support.

In order to deliver a holistic response to clients McAleenan (2000) suggestis that the following services be on offer;

- Job placement
- Local employment services
- Assessment
- Self-care
- Career guidance
- Support work
- Family support
- Literacy skills
- Childcare
- Hard and soft skills development
- Addiction awareness
- Diversionary activities.

McKeown (1998) in his feasibility study in Canal Communities, lists the recommendations made by the Lord Mayor's Commission on Drugs (1997) on the issue of rehabilitation. Recommendations made include;

- *'The concept of social employment should be developed as a rehabilitation option.*
- *Residential rehabilitation should be considered as an alternative to imprisonment.*
- *Guidance and advocacy services should be established to counter discrimination for former drug users in employment, training and education.*
- *Social rehabilitation type models should be expanded to cover areas where problems are most acute – such models should include participative adult education, personal, life and vocational skills and counselling.*
- *Extra resources should be deployed towards the establishment of drug-free treatment models tailored to the different socio-economic and cultural environment of drug users' (Feasibility study on a drug rehabilitation service in canal communities, p19).*

The argument over whether or not rehabilitation should be focused primarily on former or current users is somewhat contentious and does not seem to be resolved in the literature. The 'Rehabilitation Research Report – Towards a blueprint for rehabilitation for opiate addicts in the Eastern Health Board Area '(1999) examines rehabilitation from the clients'

perspective, the staff's perspective, and the community groups' perspective. This report emphasises the tenet that rehabilitation does not have to equate with being drug free. Interviewees spoke of the benefits of methadone as part of a rehabilitation programme. They also stated that rehabilitation should also consider abuse of other non–opiate drugs, such as benzodiazepines. However, 86% of the sample stated that they wanted to be drug free as part of, or all of their rehabilitation – suggesting that abstinence is one of the aims of many rehabilitation clients. Amongst the community group workers, the concern was expressed that rehabilitation might be reserved for the more able, better resourced, and less chaotic clients. They reiterated the importance of providing rehabilitation services which were individualised for each specific client's needs, that individualised comprehensive assessment is required on admittance into a service, that key working should be considered and that more attention should be given to clients' views on the service they receive. The need for half-way houses to facilitate the return of recovering addicts back to their communities was also stressed.

The issue of methadone distribution as part of the treatment/rehabilitation process was also raised by McKeown (1998). He refers to the South Inner City Service Development plan, which is critical of the fact that some agencies working strictly within the medical model of treatment are neglectful of the fact that psychosocial supports in addition to methadone are required,

'Treatment has become synonymous with the provision of methadone. While it is accepted that methadone has a positive role to play in the treatment of the physical aspects of drug dependence, it is imperative that it is delivered in the context of structured programmes including counselling and activities which actively engage the addict to address the psychosocial implications of their drug use.' (Section 6)

Vocational Rehabilitation - Ireland

The report 'Drugs Task Force Project Activity for FAS Community Employment Participants – A Review' (unpublished) (Bruce, 2005) stresses the importance of vocational rehabilitation and the relationship between social exclusion and rehabilitation. Bruce (2005) asserts,

'Best international practice shows that participation in the labour market is one of the surest ways to enhance self-esteem and reinforce the process of stability and recovery.' (p.33)

The interplay of poverty and drug addiction is propounded and the tenet that rehabilitation interventions do not view the individual in isolation from their broader needs is stressed.

Maintaining that the US has some of the most developed rehabilitation models, he cites studies conducted in the US in this area. The importance of securing employment in order to obtain a drug free lifestyle is emphasised. Barriers he alludes to include lack of skills, lack of motivation and general education. After reviewing a number of US vocational rehabilitation interventions, he concludes that the American experience in rehabilitation and vocational training for substance abusers emphasizes the importance of:

- Integrated and collaborative effort among agencies
- Programme assessment and staff development
- Effective strategies for vocational progression
- A balance between realistic and vocational outcomes and therapeutic needs
- Integrated and holistic approaches.

The report then turns its attention to FAS and its role in relation to the vocational rehabilitation of drug users. He refers to the First Report of FAS in 1996, which outlines a number of recommendations in relation to rehabilitation and reintegration, the importance of delivering occupational and social skills training to drug users, and the decision to give priority status to all Community Employment applicants who are recovering substance misusers.

Bruce is cautious about the current over-reliance on community employment which may not adequately address the multiple needs of drug misusers. He cites a study in 2000 by the ESRI which found that CE displayed no positive employment effects.

Taking a less pessimistic viewpoint the Indecon Report (2002) did acknowledge that CE schemes may not be as effective as other measures at enhancing employability, however it did recognise the valuable work experience it offered to participants who may have lost touch with the labour market. The Irish National Organization of the Unemployed also suggested that with suitable amendments, CE programmess may be more effective;

'with appropriate changes the programme can be significantly improved as a progression measure' (Indecon, p88).

In the aforementioned Eastern Health Board Area report (1999) on rehabilitation, securing employment was seen by those in work as crucial to their recovery. Clients spoke of an array of factors that prevented them from entering the workforce. The main reason cited was lack of training; additional hindrances were the need to be more stable, the need to get

completely clean and mandatory attendance at clinics each day. Of the 29% who received career guidance 71% found it useful.

Interviewees stressed the importance of training programmes to help secure employment. Females tended to opt for FAS courses, mostly general life-skills courses incorporating some vocational training and personal development, while males opted for specific trades, eg glaziers, tillers and chefs. A small number of interviewees in the study wanted to receive training in the area of drug counselling and addiction.

The concern about the over-reliance on CE employment and FAS training was also raised in this study. One criticism of CE employment was that clients were not encouraged to develop a serious work ethic. It was also pointed out that women receive substantially more financial incentives to go on FAS schemes than men. The need for bridging programmes to build self confidence was voiced, as was concern about pushing clients into the work force too early. A more optimal procedure as recommended by the focus group interviewees was the use of short-term, interim work programmes with achievable concrete outcomes. The importance of working closely with employers to alleviate fears about employing recovered or stabilised drug addicts was reiterated.

Another report to criticise the CE programmes was 'Fighting back: Women and the impact of drug abuse on their families and communities' (Murphy-Lawless, 2002). In this report women spoke of the major failure of CE schemes to create progression routes and in many ways were regarded as non-jobs. However, benefits of the scheme were also voiced, with some women finding them genuinely fulfilling.

<u>Residential Rehabilitation -Ireland</u>

Merchants Quay produced the report 'From Residential Drug Treatment to Employment – Mapping a Route from Exclusion to Integration - Integra Programme'. The Intergra project aimed to improve the employability, and access to employment, of people excluded or at risk of exclusion from the labour market. The report references the work of Larkin (1994), who identified four factors that reduce stabilised or former drug users' chances of finding and maintaining employment. These include;

- The stigma associated with being a (former) drug user
- The fear and ignorance of problem drug use and HIV/AIDS among employers and trainers

- Lack of recent work experience and job skills
- Personal barriers such as reduced self-esteem and lack of confidence.

Based on the work of two years of learning the report presents a model of reintegration. The aim of the project was to develop, evaluate and disseminate a model of good practice in relapse prevention using a locally based holistic programme which facilitates the integration of former drug users into mainstream training/work placement and employment opportunities. The aims of the programme which include securing stable housing, reducing offending and providing pre-employment training, are classified under three headings: integration, social stability and training and employment. The model is described as participant centred, flexible, inclusive and reflective.

The report offers insights and guidelines into programme management and guidance; referral pathways; programme overview; lapse/re-lapse interventions; working with training providers; and methods to engage employers. The importance of collaborative partnerships with other agencies is stressed. With respect to working with employers, suggestions are made on how to make high level engagement with large corporations, trade unions, chambers of commerce and employer organisations. Recommendations with respect to engaging small and medium sized businesses are put forward.

The results of the programme were positive. 65% of participants who took part in the residential programme completed it. 83% accessed a full-time job, 4% accessed a part-time job and 13% went on to further education. 90% of participants indicated that the programme had helped them with relapse prevention.

All employers completed a questionnaire at the end of participant placements. They reported that involvement in the programme had changed their perceptions of former drug users, and that participants were energetic, highly motivated and intelligent.

An EMCDDA[10] (2002) report comments on the evaluation of Aiseiri, which provides a 30 day inpatient programme and a 2 year aftercare system. The evaluation showed that 60% of clients were abstinent after completion of the 30 day inpatient programme. The evaluation

[10] Classification of drug treatment and social reintegration and their availability in EU Member States plus Norway

also showed that three-quarters of those who agreed to be interviewed reported improvements in their quality of life.

Housing - Ireland

Aside from research which focused specifically on homeless substance misusers, research on housing and drug rehabilitation in Ireland proved to be a grey area in the literature search. In the Irish literature the situation of housing seems to be more broadly linked with discussions on general social exclusion.

The Eastern Health Board Area report –'Towards a blueprint for rehabilitation for opiate addicts' (1999), touches on the issue of accommodation. The majority of the research sample lived in the family home, few lived alone. 57% were unhappy with their accommodation. Reasons given included the building itself, the locality and tensions within the household. For this reason the report recommends that any rehabilitation intervention needs to consider the family context in which the substance misuser is living. The report concludes,

'Few live alone, rehabilitation that considers clients in isolation is not accounting for the reality...it is also true that many find it difficult living in the family home. Any rehabilitation needs to consider the family context in which most addicts, recovering or using are living' (Towards a blueprint for rehabilitation for opiate addicts in the Eastern Health Board, p4).

The Merchants Quay – Integra Report states that housing was one of the most salient issues of relevance to their participant group. They comment how insecure housing can have a huge impact on participants' ability to access/retain employment and education/training opportunities. They cite Donoghue's (1999) evaluation of the Rutland-Soilse Partnership Project which argued that the greatest problem reported by programme participants was homelessness. Housing difficulties impacting on the group included;

- Having no suitable home to return to upon programme completion
- Difficulties accessing hostels
- Increasing costs of acquiring private rented accommodation
- Difficulties of returning to communities where they used drugs in the past
- Familial difficulties
- Inflexible local authorities
- Use of the Housing (Miscellaneous Provisions) Act 1997.

Rehabilitation – Modalities

Kieran McKeown (1998) conducted a feasibility study on drug rehabilitation services in Canal Communities. The purpose of the study was to investigate the feasibility of setting up a community business to run a drug rehabilitation service. Following consultation with Rialto Community Drugs Team, SAOL and Soilse he conceptualised the idea of three different models of rehabilitation, namely, the engagement model, the problem solving model and the drug free model. The purpose in identifying these three models is to map out the range of options available in the field of rehabilitation. He states that the three models may be viewed as being mutually reinforcing options rather than mutually exclusive alternatives. McKeown calls for an integrated approach to drug rehabilitation, with no one model adequately catering for drug users at every stage of their recovery. In order to engage clients in the process of rehabilitation McKeown maintains that a financial incentive is needed. The rehabilitation models which he advocates are individualised and multifaceted; *'the concept of progression implies that every drug user will require a unique, tailor made pathway which draws upon all the services available including treatment, personal development through group work and counselling, training, education, work experience and work placement .' (p.32)*

The first model is the engagement model; the name of this model is coined and does not exist in the literature. This model has not been tried before, although elements of it can be found in projects such as the Rialto Community Drugs Team, SAOL and Soilse. It sees motivation as a key resource in the rehabilitation process. It encourages the setting of manageable goals.

According to McKeown, this model redirects the energy away from drugs and into other activities.

'The engagement model sees addiction as one of a number of problems which the person seeking rehabilitation needs to address. These other problems usually include ill health, poverty, broken relationships, crime, low self-esteem, lack of education….the engagement model prefers to avoid monocausal linkages…by definition, this model presumes that drug users have the crucial say in the type of activities which will help re-channel and divert their energies towards more productive activities' (p46).

The second rehabilitation model described by McKeown is the Problem Solving Model. The description of the problem solving model draws heavily upon the work of SAOL. It is described as follows,

'the problem solving approach sees addiction as one of a number of problems which a person seeking rehabilitation needs to address…These problems may or may not be related to addiction; the problem solving model prefers to avoid monocausal linkages to endeavour to trace all problems to a common root in addiction. In particular, it recoils from what it sees as the injustice of labelling someone an addict…. the problem solving model tends to situate the problems in the overall context of the person's life whereas the drug free model tends to situate them in the context of the person's addiction.' (p.60)

In this model, progress is measured by reference to the situation which prevailed at the beginning of the rehabilitation process. Once again, complete abstinence is not always viewed as the appropriate goal, at least not in the short to medium term. It is important that individuals set their own realistic goals. This model is open to a wider spectrum of drug users, although the need to maintain homogenous group in the rehabilitation is stressed.

The third model McKeown discusses is the Drug Free Model – the description for this model draws heavily on the work of Soilse. In this model, addiction is viewed as the core problem. He states,

'The aim of rehabilitation in the drug free model is to support service participants in their desire to re-socialise themselves personally, socially, economically and culturally. Accordingly, a key requirement of the service is that participants are motivated to change their behaviour and to aspire to the goal of being drug free. The drug free model supports participants in achieving a drug-free status through a programme of activities which restores independence, self-esteem and self –direction and by breaking the dependency, social isolation, boredom and peer pressure associated with the drug spiral. An emphasis is placed on group work looking at issues such as denial, delusion and family dynamics'. (p74)

Each of these models are discussed in terms of their understanding of addiction, the specific aims of the rehabilitation model, care plan methodology, target groups, programme content, staffing, participants' allowances and cost and referral pathways. The report may act as a useful guide when attempting to develop a rehabilitation service.

Evaluation of drug services - Ireland

What drug services have been evaluated in Ireland which may provide an insight into the rehabilitation process?

- Icon Drug Support Service (2002)
- Solise-Rutland Partnership Project (1999)
- Cuan Dara (1997)
- Tallaght Rehabilitation Project (2003)
- Evaluation of Community drugs workers training course (South Inner city and canal communities) (1999)
- Stepping stones project of Ballymun Youth Action Team (2000)
- Merchants Quay Project residential programmes (1999)
- Addiction Response Crumlin (1999)
- Canal Communities (1998)
- Community Addiction Response Programme Killinarden (1997)
- SAOL (1997)
- Aiseiri
- Northside Partnership – Labour Market Inclusion Project (2003)

Concluding comments

Given the quality and comprehensiveness of recent publication reviews in the area of employment and substance abuse, a commissioned review of this area is unnecessary.

A review of Irish services such as those listed above may prove a useful exercise, to investigate how rehabilitation is practised within their setting. Shortcomings inherent in these evaluations will doubtless relate to lack of control condition (randomized or case control) but nonetheless the exercise may provide a valuable insight into rehabilitation in Ireland.

Searches of specific theoretical drug rehabilitation modalities did not yield successful results – perhaps further research could illuminate knowledge in this area, or perhaps reference will have to be made to the broader field of rehabilitation within the area of alcohol dependence, mental health and/or disability.

A worthwhile exercise may be to illustrate the importance of psychosocial interventions/therapies at different spectrums of the treatment/rehabilitation continuum, ie. when can optimal results be achieved with respect to group counselling etc., how important

is following up counselling, vocational counselling etc. once abstinence/stabilization has been achieved?

A number of reports[11] have alluded to the absence of adequate research on interventions for women. In addition, issues of rehabilitation specific to prisoners have not been elaborated upon in this review and may warrant further research.

More research may be required to untangle the difference between aftercare and rehabilitation. The UNOCD describes it as a separate component to rehabilitation; the Scottish Executive alludes to its importance after residential rehabilitation, while an EMCCDA report classifies Aftercare as one of the categories of social reintegration in Ireland.

The UK Home Office study in Lambeth which examined the importance of housing on drug misuse used an interesting methodology, seemed insightful and offered worthwhile information on the effect of housing/accommodation on drug misuse. A similar study in an Irish context may prove a worthwhile exercise.

Bibliography

Bowden (1997) Community Addiction Response Programme CARP Killinarden: review and interim evaluation report. Community Addiction Response Programme, Dublin.

Bowden, M (1997) An interim evaluation of the SAOL project. SAOL, Dublin.

Bruce, A (2005) Drugs Task Force Project Activity for FAS Community Employment Participants: A Review. (Unpublished).

Council of Europe (2000) Vocational Rehabilitation for Drug Users in Europe. Council of Europe.

Cox, G and Lawless, M (1999) Merchants Quay Project residential programmes. A report by the Merchants Quay Research Office. Merchants Quay Project, Dublin.

[11] Best Practice, Substance Abuse, Treatment and Rehabilitation. Office of Alcohol, Drugs and Dependency Issues, Health Canada, Council of Europe (2000) and South, Akhtar, Nightingale and Stewart (2001)

Cullen, B and Cox, G (2003) Tallaght Rehabilitation Project: a review report. Trinity College Dublin, Addiction Research Centre, Dublin.

Donoghue, B (1999) The Soilse-Rutland Partnership Project: an evaluation of the first year of operation. Soilse-Rutland Partnership, Dublin.

Dorman, P and Jones, L (1999) Rehabilitation research project: towards a blueprint for opiate addicts in the Eastern Health Board area. Eastern Health Board, Dublin.

Eastern Health Board (1999) Rehabilitation research project: Towards a blueprint for opiate addicts in the Eastern Health Board area. EHB, Dublin.

European Monitoring Centre for Drugs and Drug Addiction (2002) Classification of drug treatment and social reintegration and their availability in EU Member States plus Norway: Final Report. European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

European Monitoring Centre for Drugs and Drug Addiction (2003). Social reintegration in the EU plus Norway. European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

Health Research Board (2004) Report to the EMCDDA by the Reitox, National Focal Point: Ireland: Drug Situation. Health Research Board, Dublin.

Home Office Report (1994) Keys to change: A study of the role of local authority housing in the care and rehabilitation of drug and alcohol users in the London Borough of Lambeth. Home Office Drugs Prevention Initiative, London.

Lord Mayor's Commission on Drugs, 1997, Report, June, Dublin: Dublin Corporation.

McCann, MH (2000) Stepping stones to change: a discussion on rehabilitation. Ballymun Action Project, Dublin.

McKeown, K (1998) Feasibility study on a drug rehabilitation service in Canal Communities.

McKeown, K and Fitzgerald, G (1999) Treating drug addiction: an evaluation of Addiction Response Crumlin. Addiction Response Crumlin, Dublin.

McLellan, A.T, Grossman, D.S, Blaine, J.D and Haverkos, H (1993) Acupuncture treatment for drug abuse: A technical review. Journal of substance abuse treatment. 10 (6), p.569-576.

Murphy-Lawless, J. (2002) Fighting back: Women and the impact of drug abuse on families and communities. The Liffey Press, Dublin.

Murthy, P (2002) Developing community drug rehabilitation and workplace prevention programmes: partnerships for drug demand reduction in India. Report published by the United Nations Drug Control Programme, Regional Office for South Asia, International Labour Organization, and the European Commission.

National Institute on Drug Abuse – information available on http://www.drugabuse.gov/TXManuals/CRA/CRA1.html

National Treatment Agency for Substance Misuse (2002) Models of care for the treatment of drug misusers: Promoting quality, efficiency and effectiveness in drug misuse treatment services in England. National Treatment Agency, London.

National Treatment Agency for Substance Misuse (2002) Treating cocaine/crack dependence. August, Research Info practice: 1a drug services' briefing. Available on: **http://www.nta.nhs.uk/publications/research_briefing1a.htm**

Office of Alcohol, Drugs and Dependency Issues, Health Canada (2001) Best Practices: Treatment and rehabilitation for youth with substance use problems. Minister of Public Works and Government Services Canada.

Office of the Deputy Prime Minister (2005) Housing support options for people who misuse substance: Guidance for Supporting People Commissioners and Officers. Office of the Deputy Prime Minster, Drug Strategy Directorate, Home Office, London. Available on **http://www.drugs.gov.uk/ReportsandPublications/Communities/1112191005**

Peter Fletcher Associates (2004) The housing needs of people with drug, substance misuse, and alcohol problems in Cambridgeshire and Peterborough. A report for Cambridgeshire County Council and Peterborough Drug Action Team.

Randall (2000) Mapping a route from exclusion to integration. Merchants Quay Project, Dublin.

Randall, N (2000) From residential drug treatment to employment: Mapping a route to integration. The Merchants Quay Project.

Rawlings, B and Yates, R (2001) Therapeutic Communities for the treatment of drug users. Jessica Kingsley Publishers, London.

Roberts, G, Ogborne, A, Leigh, G and Adam, L (1999) Best Practices: Substance Abuse Treatment and Rehabilitation. Minister of Public Works and Government Services Canada.

Rourke, S (1999) Evaluation of community drug workers training course. Community Response, Dublin.

Rush, M (2002) Icon Drugs Support Service: evaluation report October 2002. Icon Drugs Support Service, Dublin.

Rutter, D. (1994) Keys to change: A study of the role of local authority housing in the care and rehabilitation of drug and alcohol users in the London Borough of Lambeth. Home Office Drugs Prevention Initiative, London.

Scottish Executive (2000) Moving on: Education, training and employment for recovering drug users. Scottish Executive, Edinburgh.

Scottish Executive (2003) Moving on update: education, training and employment for recovering drug users. Scottish Executive, Edinburgh.

Scottish Executive (2004) Residential detoxification and rehabilitation services for drug users: A review. Scottish Executive, Edinburgh.

Scottish Executive (2004) Rural and Remote Areas: Effective approaches to delivering integrated care for drug users. Scottish Executive, Edinburgh.

Scottish Executive (2004) Working with young people: A profile of projects funded by the Partnership Drugs Initiative. Scottish Executive, Edinburgh.

Scottish Executive (2004) Young people with, or at risk of developing, problematic substance abuse: A guide to assessment. Scottish Executive, Edinburgh.

Smyth, BP and Lane, A (1997) Audit of the first twelve months of Cuan Dara detoxification unit July 95 to July96. Cuan Dara, Dublin.

The Addiction Technology Transfer Center Network – **http://www.ceattc.org/nidacsat_bpr_ebp.asp**

United Nations Office on Drugs and Crime (2002) Contemporary drug abuse treatment: A review of the evidence base. United Nations. New York.

United Nations Office on Drugs and Crime (2003) Drug abuse treatment and rehabilitation: A practical planning and implementation guide. United Nations, New York.

United Nations Office on Drugs and Crime (2003) Investing in Drug Abuse Treatment: A Discussion for Policy Makers. United Nations, New York.

United Nations Office on Drugs and Crime: **http://www.unodc.org/unodc/treatment_toolkit.html**

Appendix

Rehabilitation key word search

Key words searched were **rehabilitation, reintegration, and social integration**, these were then cross searched with the below words

Drug abuse
Substance misuse
Employment
Interventions
Therapeutic
Community-based
Psychosocial
Best practice
Modalities
Modality
Vocational
Drug users
Stabilization
Holistic therapies
Heroin

SECTION TWO

DRUG REHABILITATION SERVICES IN IRELAND: A REVIEW OF PROJECT EVALUATIONS

Una Molyneux

Drug Rehabilitation Services in Ireland: a review of project evaluations

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Treating Drug Addiction: An Evaluation of Addiction Response Crumlin. *Date:* 1999 *Author* Kieran McKeown & Grace Fitzgerald *Name of Programme:* Addiction Response Crumlin (1999)	*Aims:* To expand its treatment services into a more comprehensive rehabilitation programme. *How define rehab:* Treatment approach of stabilizing clients on the heroin substitute methadone. In addition, offering ancillary services such as advice, counselling and various group activities. Rationale for this approach is that clients who stabilize on methadone can, after a suitable period of time, progress to detoxification	*No of clients on programme:* Circa 250 (Jun-96 – Dec-98). Average no. of clients receiving a service at any time during 1998 was circa 75 (with waiting list around 30). *Target Group:* Heroin users who wish to stabilize their lives by taking heroin substitute, methadone, as first step to becoming drug free. *Cost of programme:* IR259,702 (Dec-97 – Dec-98). *How long in operation:* Jun-96 – Dec-98	*Service inputs:* Key service input is prescription of methadone and related monitoring of its use through urine and blood analysis. The project also provides a drop-in service, counselling and various forms of group work such as women's and men's groups, art, drama and music groups. All clients – apart from those who are drug free – are on methadone but there is also a very high uptake of the drop-in service (83, 91%) and the counselling service (67, 74%). Well over half participate in some form of group activity and nearly half (44, 48%) attend Narcotic Anonymous. Methadone is prescribed on a weekly basis but given the nature of addiction, ARC has established a dispensing system	*Proportion of clients who have stabilized on methadone; proportion who have become drug free, and proportion who are still using either heroin or a combination of other drugs.* Nearly three quarters of all clients (66, 72%) have progressed beyond this point to a more stable habit or to a drug free life. Nearly half of all clients (44, 48%) are on methadone but more than a quarter (25, 27%) have become drug free; a similar proportion (22, 24%) appear to have made no improvement. *Note[1]:* the achievement of a drug-free lifestyle was greater among women (37%) than among men (23%), even though twice as many men (61, 67%) as women (30, 33%) attend ARC. *Note[2]:* Comparative data on drug treatment outcomes in Ireland is not easy to obtain since many evaluations tend to focus on client	*Poor Case Management:* Poor management of individual cases in helping clients in moving to a drug free life (e.g., drug free clients spend less time on the project than drug using clients; tendency for some drug using clients who are on methadone to see themselves as already drug free). *Poor Care Planning:* The service can be ad hoc and there seems to be little emphasis on developing and negotiating a detailed care plan with each client which would involve a mutual commitment by the project and the client to that plan. In particular, the service seems to lack a systematic approach to case management which would involve setting targets in all the key areas of need. It is possible that the absence of such an approach is leading some drug clients to drift on the project and to see methadone maintenance as a point of destination rather than a point of departure to the next stage of recovery. It is also possible that the absence of care planning may be leading to the project to overlook the need to link clients into education and training initiatives which would contribute to their overall personal development as well as improving their position in the labour market. Quite apart from these considerations, the potential of a more systematically organized care plan for each client would be worth considering on the grounds that it would help to ensure that each client receives a uniformly high quality service	*A Drug Free Lifestyle:* Of the 91 clients covered in the survey, 27% (25) had progressed to a drug-free life. However, achievement of a drug-free lifestyle was greater among women (37%) than among men (23%). Given that all clients who come to ARC are either using heroin or a combination of other drugs, it is significant to note that nearly three quarters of all clients (66, 72%) have progressed beyond this point to a more stable habit or to a drug free life. Nearly half of all clients (44, 48%) are on methadone but more than a quarter (25, 27%) have become drug free; a similar proportion (22, 24%) appear to have made no improvement. The achievement of a drug-free lifestyle was greater among women

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	detoxification and then begin living a drug free life.		which ensures the client is nominated to hold the methadone and administer it on a daily basis. In nearly half of all cases (31, 48%), the prescription is held by the parents or other family member. ARC staff hold the prescription in a third of cases (21, 33%) and the chemist dispenses daily in a fifth of cases (12, 19%). *Staff:* Staff in ARC offer a highly personalized and supportive service to each client. Main function is to support clients on methadone treatment programme. This takes a variety of forms: the "buddy system", driving to pharmacies outside area to collect methadone for clients, visiting clients at home in order to offer practical help with health, social services, housing or whatever their presenting need;	satisfaction and related variables rather than on changes in drug using behaviour. However one evaluation of the Merchants Quay Project in 1993 found that only half of the clients showed any improvement in their drug using behaviour compared to three quarters of ARC clients (McKeown, Fitzgerald and Deehan, 1993, p.71). Second, a programme in the north inner city of Dublin aimed specifically at producing drug free outcomes has reported that more than a third (30, 37%) of its 81 admissions had become opiate free (Crowley, Callery and McColgan, 1998). This would appear to be a superior outcome to ARC although it should be noted that ARC is not oriented exclusively to drug free outcomes and is therefore much less selective in its intake. Overall therefore ARC is an effective form of intervention for drug users and compares favorably in	service. *Gender Issues:* The third issue concerns the different needs of drug using men and women. Analysis indicates that, proportionately speaking, fewer men become drug free than women. Also, those that become drug free take longer on the project to achieve it. At the same time, men seem more likely than women to take up employment as well as education and training. This suggests that men may need more intense support during and after detoxing than is currently on offer. By contrast, women drug users were more likely to assess their health as poor and to be more involved in criminal activities than men. None of them have undertaken any education or training programmes and women in general tend to have higher levels of unemployment than men. These considerations, in conjunction with the fact that many women are also active mothers, point to the need for more careful consideration of how to promote women's health, their personal development and their overall level of education and training. Note[1]: All clients require a carefully negotiated and well resourced care plan to meet the same core needs stemming from their addiction and the difficult life circumstances which each has experienced. *Partnership Issues:* The work of ARC demonstrates the difficulties which many community groups in Dublin are	(37%) than among men (23%). This result compares favourably with the outcomes of other treatment programmes. *Health gain:* The progress made by clients in stabilizing or eliminating their drug use is a clear health gain associated with the project. All drug free clients and eight out of ten drug using clients claimed that their health had improved since attending ARC. Nevertheless it is significant that less than two thirds of clients (57, 62%) rate their health as good or excellent in view of the young age of clients. Women drug users rate themselves as least healthy. *Social Gain:* Nearly nine out of ten clients (80, 89%) reported an improvement in the quality of their lives; this was particularly

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			visiting parents of clients in order to help overcome the isolation, loneliness and stigma which is often associated with addiction in the family; facilitating group activities for clients and parents to build up their supports and confidence. *Addiction Course:* The project also organized an addiction course for people in the area – attended by eighteen women and five men – to raise awareness and understanding of problems of addiction; this stretched over 20 evenings and one weekend between 1997 and 1998. A second year of this course ran between 1998 and 1999. *Support Groups:* In addition to methadone treatment, the project offers its clients a range of support groups – women's groups, men's group, art group, drama	its outcomes with other drug prevention programmes. *Health Gain:* Survey of clients indicated very significant improvements in their self-assessed state of health. All drug free clients claimed that their health had improved since attending ARC and eight out of ten drug using clients (53, 80%) reported an improvement in health. This is significant particularly because, four out of ten have known drug related illnesses, particularly Hepatitis C. The difference between drug free and drug using clients is particularly pronounced when they are asked to assess their own state of health: most of the drug free clients rate their health as good or excellent (34, 96%) compared to only half (33, 50%) of the drug using clients. Women drug users appear to be the least healthy with just over a third (7, 37%) assessing their current state of health as good or excellent.	experiencing in trying to work in partnership with the statutory agencies but more particularly with other local residents. ARC has received considerable support from the community but this is still much less than required to fully develop a comprehensive drug rehabilitation service. The resistance of other local players in the community to the use of premises for drug services has made ARC's work more difficult. These experiences highlight the importance of local leadership in tackling the drug problem, particularly by those who control access to resources such as facilities. *Need for Holistic Approach:* Evaluators suggest the need for a holistic approach to the needs of drugs users and the corresponding requirements for different agencies – whether in the areas of health, education, training, employment or law – to co-ordinate their activities in order to remove the harmful blockages which hindered drug users from becoming fully adult members of society. *Drug use and families:* Drug use must address the needs of drug users and their families as well as the needs of the wider community in terms of access of quality services and opportunities. In the longer term, it means preventing drug use by supporting vulnerable families to overcome their problems and ensuring that all of the services in the community – particularly in the areas of childcare, family support, education, training, and youth services – are	this was particularly pronounced among the drug free clients. *Reduced Unemployment:* Unemployment fell by over 20% since they started attending ARC. The decline in unemployment was twice as great for drug free clients (40% reduction compared to 20% reduction) and, within this group it was three times greater for men than for women (57% compared to 18%). *Reduced Criminal Activity:* Since attending ARC, there has been a dramatic reduction in the involvement of clients in criminal activity; prior to attending ARC two out of three clients were involved in criminal activities compared to just over a fifth since attending ARC. *GP Methadone*

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			group, art group, drama group and parents – to enhance the treatment process and these have varying degrees of uptake among the client group, usually between five and ten clients per group per week. Note: One of the differences between ARC and the health board's satellite clinics is that project staff – who are not employed by EHB – control admissions to and suspensions from programme in consultation with prescribing doctor. The EHB believe this function should be left exclusively to the prescribing doctor; the project believes that this should be a shared decision reflecting the partnership between the community and health board. *Attendance:* On average, clients spend 14 months in ARC.	*Social Gain:* Survey of clients revealed that nearly nine out of ten clients (80, 89%) reported an improvement in the quality of their lives. As might be expected, drug free clients were more likely to report an improvement than drug using clients. Clients also reported improvements in the quality of their relationships, particularly with their mothers (76%), fathers (59%), siblings (69%), partners (69%), children (73%) and friends (60%). *Changes in Employment:* Substantial improvements in the employment situation of clients since attending ARC. Unemployment has fallen from (63, 69%) on entry to over 20%. The reduction in unemployment was twice as great for drug free clients as for drug using clients (40% compared to 20%) and, within this group, it was three greater for men than for women (57% compared to 18%).	education, training, and youth services – are capable of preparing young people for the transition to adult life. This clearly is not the case at present. *Drug Use and Education:* The culture of low expectations needs to be challenged and changed using whatever resources are necessary to do so. In breaking the cycle of educational disadvantage, the current needs of clients for education and training should not be overlooked. It is clear that the future employment prospects of many clients are not promising with their current levels of education and training and both FAS and the VEC should play a key role in meeting this need. *Drug Use and Parenting:* ARC have proposals to develop a childcare facility for the children of clients. However the project has been unable to find premises because there is not a willingness to allow community-based facilities to be used for this purpose. *Drug Use and Youth Services:* In addition to family supports and childcare, there appears to be a particular need to develop services for young people. Youth and recreational activities could be important for these young people as a way of channeling their energy and skills and having fun. It is perhaps too often forgotten that young people become involved in drugs because they seek in them the pleasure that is absent from most other parts of their lives.	*Prescribing:* ARC has helped local drug users to find doctors (GPs) who are willing to prescribe methadone and pharmacists who are willing to dispense it. Note: The experience of ARC demonstrates the enormous contribution which a local community can make to addressing the problem of drug addiction. Government policy increasingly acknowledges the important role which the community and voluntary sector can play in addressing drug use and other forms of disadvantage and the work of ARC confirms the correctness of this policy approach. *Core Finding:* The core finding of this evaluation is very encouraging because it shows that ARC is having a decisively positive impact on the

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			Drug free clients spend less time on the project than drug using clients (11 months compared to 15 months). In addition, drug free women spend considerably less time on the project than drug free men (9 months compared to 13 months). The findings suggest that the likelihood of becoming drug free does not increase with length of time on the project. To become drug free, clients go through a detoxification process. Seven out of ten clients (64, 70%) have detoxed twice on average; the remainder (27, 30%) have never detoxed. Drug using women were more likely to detox than any other category of client. The overall rate of attendance at ARC is good. More than six out of ten (52, 57%) have never dropped out	Note[1]: There can be little doubt that the reduction in unemployment was influenced by the work of ARC in helping clients to live a more stable lifestyle. Note[2]: the level of unemployment among ARC clients (40, 44%) is still more than seven times higher than the national level of unemployment. *Changes in Education:* Since attending ARC, less than one in five (15, 16%) have attended any education or training programme. Drug free clients, but especially drug free men, were much more likely to have attended an education or training programme since attending ARC. *Criminality:* Since attending ARC, there is a dramatic reduction in the involvement of clients in criminal activity to just over one fifth (21, 23%). As might be expected, drug using clients have more than three times the level of involvement in criminal	*Drug Use and Gender:* There are gender differences between ARC clients which merit reflection. It is striking to note, on the basis of the information collected, that men seem to be consistently more harmed by their life experiences than women. There is almost no awareness of men's issues in these treatment services. The rationale for gender specific initiatives for drug using women is typically based on the fact that they often have parenting responsibilities and supporting vulnerable parents is clearly desirable. Gender specific drug treatment projects need to cover both genders and they also need to reflect the overall gender proportions of the target group in question. This is not the case at present. Interviews with clients indicated that many of those who have stabilized on methadone regard themselves as drug free and this may help account for the longer time spent by drug using clients on the project. This may have implications for the case management of individual clients.	lives of clients and is meeting a genuine need in the community. It is effective in stabilizing drug users and helping them progress to a drug free life. As a consequence of this, it is improving the quality of life for clients as well as the quality of their family relationships. It is making a huge contribution to the reduction of drug-related crime with corresponding savings in state resources because of fewer arrests, court proceedings and prison sentences. These outcomes indicate that ARC is providing an effective and much needed service in Crumlin and is an excellent example of partnership between the health board and the community. It deserves the support of the community as well

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			or been suspended. There is no difference between drug free and drug using clients in this regard although drug free women were least likely to either drop out or be suspended.	activity as drug free clients (29% compared to 8%), and perhaps more unusually, women drug users are nearly twice as involved in criminal activity as men drug users (42% compared to 23%). Since attending ARC, arrests among clients fall from 66% to 21%, court appearances fell from 66% to 13% and imprisonment fell from 35% to 1%.		as the statutory and voluntary agencies which have a role in responding to the needs of these clients. *Impact of the Project:* Analysis suggests ARC is having a decisively positive impact on the lives of clients and is meeting a genuine need in the community. It is effective in stabilizing drug users and helping them progress to a drug free life. As a consequence of this, it is improving the quality of life for clients as well as the quality of their family relationships. It is making a huge contribution to the reduction of drug-related crime with corresponding savings in state resources because of fewer arrests, court proceedings and prison sentences. There is little doubt that many clients have been able

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						to avail of new employment opportunities as a result of their contact with ARC. These outcomes indicate that ARC is providing an effective and much needed service in Crumlin.
Aislinn Adolescent Addiction Treatment Centre: Evaluation Report. *Author:* Dr. Gemma Cox and Barry Cullen, Addiction Research Centre, TCD. *Date:* August 2002.	*Aims:* To provide an induction for young substance misusers into lifetime recovery, through an intensive, concentrated six-week residence.	*No. of Clients:* From Oct-98-Aug-01 a total of 264 clients presented at and accepted into Aislinn (28% female, 72% male). Average age on intake: 17.6 years. *Target Group:* Male and female adolescents drug and alcohol substance misusers between ages of 15 and 21 years.	Only dedicated residential drug free center specifically for treating drug, alcohol and other addictions among male and female adolescents between ages 15 and 21 years in the country. First of its kind in Ireland. Subsidiary of Aiseiri. Provides 6 weeks highly structured residential treatment followed by two years of after-care. *Programme:* Based on Minnesota Model (Cook, 1988), (use of Twelve-step philosophy of AA as foundation of therapeutic change.	*Length on Programme:* • Average length on programme was 29.7 days (range 1-59 days). • 52% completed residential treatment. • 3% left treatment with staff approval. • 25% left at staff request. • 20% were self-discharges and left against staff advice.	*Recommendations (For Adolescents):* In treatment, adolescents must be approached differently than adults because of their unique developmental issues, difference in values and belief systems, and environmental considerations, such as strong peer influences. *Lack of Knowledge (Adolescent Addiction):* Little is known about the pattern of adolescent substance misuse in Ireland. Research indicates that poly substance use is the norm among many young substance misusers. *Lack of Adolescent Addiction Programmes:* Few programmes dedicated to treatment of adolescent substance misusers. Evidence to suggest that Minnesota Model and other Twelve-step approaches are successful for adults, however far less is known about their effectiveness for adolescents. Some studies show favourable outcomes, however research hampered by methodological	*Positive Impressions:* • Respondent's first impressions of Aislinn were very positive. Individuals spoke about feeling very welcome, safe and secure. • Said house was very homely and comfortable and that staff and residents were all very friendly. • Young people settled in very quickly and adjusted to routine of the programme. *Self-Reported Changes:* *Family Relations:*

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		How Long in Operation: Established in Oct-98.	*Key Tenets of Minnesota Model applied: :* 1. Belief that substance-dependent individual can modify and change his/her beliefs, attitudes and behaviour. 2. Treatment goals include abstinence from all mood-altering chemicals and a general improvement in lifestyle (i.e. remove addiction transference to another substance). 3. Approach supports the disease concept of substance dependency, characterized by loss of control over use, coupled with belief that drug dependency is a chronic and progressive condition. Treatment goals are		limitations, and little known about processes that govern change among those who derive benefit from Twelve-step programme. *Complex Client Problems:* Overall, the young people, who participated in Aislinn Adolescent Addiction Treatment, are serious poly substance misusers with complex behaviour, social and legal issues. *Limited Client Programme Understanding:* Participants (both young people and parents) did not know what to expect from Aislinn Centre. Limited understanding of the programme's philosophy, structure of the programme, its aims and objectives, their role in the treatment philosophy and what was expected of them. *Confusion About Family Involvement:* Family involvement in programme is considered vital. Although parents knew from outset they were expected to get involved in programme, exact nature, extent and purpose of their involvement was unclear. As parents progressed through the programme and observed others experiences, they learnt what was expected of them, and they got some insight into the therapeutic process.	While in residential treatment, most reported: • Positive changes in their relationship with their parents and siblings. • Increased communication between family members. • Individuals within family getting on better together. • Growing awareness of consequences and effects of their behaviour on their family. *Attitudes to Drugs and Alcohol:* • Many reported that Aislinn had changed the way they feel about drugs and alcohol. • Others still had desire to drink or take drugs, but more aware of consequences of their drug and alcohol misuse.

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			total abstinence from mood-altering substances and improved quality of life. *Initial Screening:* First contact with Centre at screening appointment, on site. Potential participants screened via brief questionnaire and Jellinke chart (to assess severity of dependency). Parents /guardians participate in screening process, which was difficult for some young people, particularly when parents knew very little about their sons/daughters drug and alcohol misuse. This may prevent some young people from divulging the exact details of their substance using careers. *Treatment Consists of:* • Group therapy. • Individual therapy. • Didactic lectures and group		*Discomfort with Group Work:* Respondents initially felt uncomfortable in group, unsure of what happens, and what expected of them. Individuals had to feel safe and trust other group members before they were prepared to participate, and that took time. Although the young people found the group work very beneficial, they found it very difficult 'opening up'/ reluctant disclosure. *Difficulties with Step-Work:* While in residential setting, young people usually work through first five of Twelve-steps. For many, main problem was trying to remember everything, actually concentrating on step-work; and amount of reading and writing that such a task requires. However, the step work was very effective in assisting the young people to focus on the consequences of their drug and alcohol misuse. *Stressful Family Day:* All respondents found family day stressful. Many young people spoke about pain and hurt of being confronted by family members over things that happened in the past. However, all recognized the benefits of this process and young people spoke about how the process changed their relationship with their parents and siblings. Parents spoke about how difficult it was to confront their sons/daughters, and how emotionally and mentally draining these days were. However, parents found great support in each other, and comfort in knowledge that they were not	*More Emotional Stability:* • Young people spoke about feeling less aggressive, less argumentative, and more prepared to listen to others. *Three-Month Follow-Up:* • 9 (of 13 original respondents) attending after-care (although 2 were very erratic in attendance). • 1 had started an apprenticeship. • 4 were doing FAS courses. • 2 had got jobs. • 1 was job-hunting. • 6 had returned to family home. • 3 had moved into support accommodation away from their city of origin. • Only 3 of young people interviewed at follow-up had lapsed and all 3

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			discussion. • Individual assignments. Majority of treatment occurs in therapeutic groups, which focus on seeing a broader reality; overcoming denial and gaining a greater acceptance of personal responsibility and hope for change; education about addiction and related factors; introduction to 12-step philosophy and AA/NA groups; recreational groups; groups for individuals to tell their stories and receive feedback. Individual therapy also provided, to review progress and address issues that might be too sensitive for a group setting. *Main Components (Minnesota Model):* • Group therapy. • Disease lectures. • Use of recovering		alone in this situation. *Reluctance to Total Abstinence:* Most young people in-treatment found it difficult to accept abstinence from all mood altering substances (in particular, the need to stay off alcohol, which they did not perceive as a problem for them). Hence, reluctant to accept need for abstinence. *Difficulty Leaving Aislinn (Vulnerable Clients):* All young people interviewed at follow-up found leaving Aislinn hard. They felt very vulnerable and unprepared. Generally, found 'recovery' much more difficult than they had anticipated. Found it difficult to cope with incidences and events in their lives without alcohol and drugs. Many spoke about feeling isolated from their peers. *Assessment:* Assessment is a process that informs intervention planning by ascribing the severity and pattern of misuse, and how the substance misuse affects the young person concerned. As treatment should be tailored to meet the needs of the young person a comprehensive assessment is essential, and it should be ongoing through the duration of treatment (as needs change). The assessment plays a vital role in determining an individuals' particular constellation of strengths, problems and needs, and in identifying a programme of intervention to meet those needs.	spoke about this in the aftercare group and had returned to their recovery. • Only 1 reported involvement in crime post-treatment. *Therapeutic Benefits of Aislinn Rehab Programme:* 1. Respite from street life, from the drug culture, and from drugs themselves. The importance of this should not be underestimated. This respite provides the young people with a freedom from the stresses of their daily lives. Moreover, freedom from the control of drugs, albeit for a short period, represents a major shift in the adolescent's life. 2. The programme provides the young people with

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			addicts as primary counsellors. • Use of multidimensional staff. • A Therapeutic milieu. • Family counselling. • AA (or when appropriate NA) attendance. • Daily reading for the AA 'Big Book' • Sharing of one's life history. • Working the first five steps of AA. • Recreational and physical activity. There is recognition that needs of adolescent substance misusers differ to adults, demonstrated: • Adolescent friendly • Recreational and creative components. • Highly ordered programme. • Daily structure focused on structured one-to-one, group therapy,		*Assessment (Recommendations for Change):* • Abolish current screening procedure, as the role of a residential addiction treatment center is not screening for substance misuse. • Discourage self-referral. Potential participants should be screened by local health board personnel and referred to Aislinn for assessment, if and only if intensive residential 12 Steps treatment is considered appropriate. • Replace screening process with a comprehensive assessment process, whereby young people are assessed and the nature and severity of their substance misuse determined. • Conduct part of the assessment interview using a standardized instrument. There are a number of standardized instruments (of known validity and reliability) appropriate for an adolescent population. Recommended that the T-ASI *Teen-Addiction Severity Index* be used. • Support standardized assessment with a more interactive style informal assessment interview whereby client and assessor work together to get a shared understanding of the nature of the young person's difficulties and the client's past and present life story. • Carry out assessment in private with the young person. It is paramount that the young person provides a frank and honest account of their substance misuse and	structure. There was a certain comfort found in the predictable structure of the day. 3. Positive impact on the family dynamic. The chance to sit down in a safe and supportive environment with a counsellor and their family made a difference t them and their relationship. 4. The programme helps the young people to develop links with stable adult institutions. Many of the young people had had quite negative views of adults, such as teachers. However, their experience at Aislinn help to dispel some of these views.

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			group information sessions on programme philosophy, and step work. *Family Involvement::* Family involvement is crucial component of programme. From the outset families are part of screening and intake process. Family members are then required to attend family programme, each Wednesday, 10am-5pm, for the six weeks of residential treatment, and to make a social visit on Sunday afternoons. Family day consists of family conference, joint group sessions, step work, and education sessions. *After-Care:* The importance of after-care was emphasized to help young people to sustain a changed lifestyle and adapt to family, school, work, and community following six-week		related issues. • Obtain consent. The provision of treatment requires consent. In order for a young person to consent to treatment they must be made fully aware of the nature of the treatment, and what is required of them. Therefore, the young person must be fully informed of the programme's philosophy, structure and content, to enable informed consent to treatment. • Assess the maturity of the young person, particularly as they are required to engage in group work and comply with confidentiality requirement of the programme. • Train all staff involved in the assessment of young people to be capable and trained to an agreed level of competency. *Programme Structure and Content (Recommendations):* • *Explore Other Models:* In addition to drawing from 12 Step models, the sub-committee might also look at other Irish-based social, educational and vocational programmes for young people who are troubled or in difficulties. • *Recreational Aspects:* More outdoor activities, more art and drama and various ways should be explored for utilizing modern media and communications (TV, radio, video; computers) for personal and social development. • *Family Programme:* Needs to be described more clearly as an educational	

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			period of intensive residential treatment. Thus, attendance at meetings provided by Aislinn in four locations (Kilkenny, Limerick, Cork, and Dublin) and NA/NN is essential component of programme.		and support programme for families of persons in residential treatment. • Where indicated, families who need or require family therapy or counselling in relation to deeper family issues and traumas should be provided with proper guidance toward an appropriate family therapy service. • *Key Workers:* Each Aislinn resident should have an external keyworker who should continue to have an important role throughout placement in supporting the placement, advocating on their behalf and in agreeing plans for discharge or aftercare. *Staffing (Recommendations):* • A multi-disciplinary team should provide the service at Aislinn. • All workers must have generic skill sin drug and alcohol misuse. • At least one staff member trained in: child and adolescent development (with detailed understanding of implications of major events such as abuse, bereavement and other traumatic incidents in the lives of young people). • Substance misuse assessment, referral and joint work (with ability to assess the severity and risks of substance of abuse, complexity of a planned intervention, able to recognize need for more specialized and long term interventions and ability to assess the competency of a young person to consent to treatment.	

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					• Skills and procedures for dealing with distress and disclosure of abuse. • Essential that all members of staff engaged in counselling relationship with residents receive regular and ongoing supervision in relation to their counselling work, ideally within the service for full accountability, with cost of supervision borne by the service, not the supervisee. *Staff Training (Recommendations):* Comprehensive training, supervision and support for all staff who work with children and young people. Staff should receive training in: • Other treatment models and in other theories of substance misuse. • Issue of dual diagnosis and that multidisciplinary response may be required. • Child-centred counselling skills across a wide range of issues. • Skills in multidisciplinary work and recognition of professional boundaries of expertise. • Training needs regularly reviewed. • Issue of personnel supervision should be separated from training and cost of this should not be provided through a training budget. *Relapse Prevention (Recommendations):* Some form of relapse prevention is needed, as recovery process is complex and its	

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					dimensions not clearly understood. For this purpose, Aislinn provides an aftercare service. Primary goal is to prevent young people from returning to drug and alcohol misuse. However, • There is a need for closer collaboration between Aislinn and local community based services/professionals in planning and delivery of relapse prevention. • Individuals should be screened before entering aftercare to identity those ready for traditional aftercare and those who need further drug-user treatment. • Length of Aftercare programme should be reduced to help ensure attendance, over crucial first six months post treatment. Recommended that attendance at aftercare is compulsory for first 6 months, optional thereafter. • Relapse rates indicate that total abstinence may be an unrealistic objective and from a research perspective may lead to treatment outcome measures that are insensitive to real though not absolute changes in drug use behaviours.	
Blanchardstown EQUAL Inter-agency Initiative (2003) *Author* Cathal Morgan	The primary aim is to enhance opportunities for current and former drug users from Blanchardstown to progress towards	*No. of clients on programme:* 11-20. *Target group:* Adult former and current drug users – all substances.	*Settings:* Urban, Local, Community, In-patient setting (therapeutic community), Out-patient setting (general services). The main assumptions underpinning this initiative centre around current and former drug	Survey of front-line agency staff; Focus group interviews with service users. *Evaluation Indicator 1:* Evidence of improved cooperation between agencies; Increase in inter-agency referrals; Perception of service users to	No mention in EDDRA evaluation summary. Poor co-operation between agencies.	As part of the evaluation of the pilot phase a facilitated focus group session was held with eight clients in early September 2004. All the clients had been through the inter-agency initiative and

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Terry McCabe *Name of Programme:* Blanchardstown EQUAL Inter-agency Initiative EDDRA Evaluation 2004	employment opportunities. *Specific Objective 1* Improvement in the quality of service and working relationships between all agencies involved. *Specific Objective 2* Development of a 'lead agency' approach to case management, through which one agency assumes the lead role in assisting service users and would also coordinate the contribution of other participating organizations. *Specific Objective 3:*	*Strategic Target Group/change agents.* Intermediaries addressed in order to reach the final target group: • Self-help group • Health professionals • NGO's • Community drug teams *Cost of programme:* Total budget from 10,000 to 50,000 euro. . *How long in operation:* 2002-2004. Ongoing Programme since 01-Feb-03.	current and former drug users being prevented from progressing to labour market opportunities because agencies working with them do not share information and resources that might otherwise assist service users in availing of labour market opportunities as they arise. To improve this situation this initiative is premised on the belief that agencies working with current and former drug users can provide a better quality service by working together through an inter-agency approach. The eight agencies involved carried out extensive collaborative work from the middle of 2003 to February 2004 in developing a number of protocols to underpin the future of this inter-agency initiative. This work was assisted and guided	of service users to initiative. Preliminary evaluation results show that co-operation between agencies is improving particularly on the challenging issues of 3-way meetings and lead agency referrals. 3-way meetings refer to a meeting between the lead agency, the agency the client has agreed to be referred onto and the client. Number of 3-way meetings increased from 0 in February to seven in March to ten in April 2004. The evaluation noted that 3-way meetings were consistently reported as being positive both for introducing clients to new agencies and for resolving issues arising for clients between agencies. All the clients had been through the inter-agency initiative and found it to be an improved way of working. According to the evaluator, they questioned why it was not used everywhere when it had so many advantages for service users.		found it to be an improved way of working. According to the evaluator, they questioned it was not used everywhere when it had so many advantages for service users.

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	Objective 3: Development of clear and workable protocols, especially with regard to service/client confidentiality. *How define rehab:* Attempting to meet the training, education and employment needs of drug users in the Blanchardstown area.		by an independent facilitator. Development of a 'lead agency' approach to case management, through which one agency assumes the lead role in assisting service users and would also coordinate the contribution of other participating organizations, protocol agreed by all agencies. According to the protocol, a lead agency assumes the most significant role in providing and co-coordinating services to a client including the provision of a key worker. Responsibilities include carrying out a needs assessment, holding and managing the overall care plan and tracking and following up on a client to prevent 'a fall through the cracks'. In addition, a protocol on confidentiality has been developed and adopted	*Evaluation Indicator 2* Development of a protocol on Lead Agency working agreed by all agencies. Developments to date include a protocol on Lead Agency agency working, which provides a definition of the term and establishes the responsibilities of the lead agency. According to the protocol, a lead agency assumes the most significant role in providing and co-coordinating services to a client including the provision of a key worker. Responsibilities include carrying out a needs assessment, holding and managing the overall care plan and tracking and following up on a client to prevent 'a fall through the cracks'. The lead agency approach is seen by most agencies as having clarified the roles of other services and allowed the interventions to be client-focused. Number of Lead Agency referrals increased from 0 in February to two		

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			by all eight participating agencies, covering areas such as the limits of confidentiality, sharing client's information, working with under 18s and accommodating clients' access to files containing information on them. The development of the protocols followed extensive inter-agency work from mid-2003 to February 2004 assisted by an independent facilitator. *Actions* Six month programme for drug users. • advice and support • brochures/leaflets • community drug team • • education (skills, abilities, etc.) • rehabilitation • reinsertion/social insertion	in March to four in April 2004. *Evaluation Indicator 3* Development of agreed protocols; Agreement by all agencies to mainstream protocols; Development of agreed protocol on Client/Service confidentiality The eight agencies involved carried out extensive collaborative work from the middle of 2003 to February 2004 in developing a number of protocols to underpin the future of this inter-agency initiative. This work was assisted and guided by an independent facilitator. A protocol on confidentiality has been developed and adopted by all eight participating agencies, covering areas such as the limits of confidentiality, sharing clients' information, working with under 18s and accommodating client's access to files containing information on them. Measurement of the results in terms of outcome/impact		

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			• work .training/labour .training	has not been evaluated yet.		

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Feasibility Study on a Drug Rehabilitation Service in Canal Communities. *Author:* Kieran McKeown. *Date:* June 1998.	*Aims:* To attract drug users who, for whatever reason, feel alienated from other services. *How define rehab:* Integrated Approach: No single rehab programme can meet all the needs of a drug user at every stage of their recovery. Even the addiction problem – however defined – may require a different approach as client moves between the different stages of drug use – problematic (i.e. severe, moderate, mild), stable (i.e., prescribed drugs/non-prescribed	*Target Group:* There are substantial numbers of drug users in every category in Canal Communities, all of which have multiple problems. Accordingly, service targeted primarily at: 1. Methadone users - we would expect that most of them are also using other drugs as well (i.e. mono-drug users, poly drug users, single	*Case Management:* All key agencies in health, housing, income maintenance, education, training, job placement, – work in consort to provide an integrated set of supports for that person; clinical management, which involves regular review of client's medication requirements, is an important sub-set of this, but only a sub-set. *Care Planning:* A care plan is drawn up by the service user with the assistance of a key worker and sets goals in each area of the person's life as well as mapping out the steps – both therapeutic and otherwise – needed to achieve these goals. *Note:* Both case management and care	A service which succeeds in attracting and retaining drug users is also meeting one of the necessary conditions for effectiveness. May be less effective if measured in terms of its capacity to attract and retain more problematic and less motivated drug users. Propose to measure service effectiveness by reference to its capacity to attract and retain drug users and its capacity to produce beneficial outcomes.	*Methadone Maintenance without Rehab:* The gap in services for methadone users is particularly pronounced and well known. Indeed the use of methadone without corresponding rehab options may be counterproductive to the point of increasing rather than decreasing harm.	

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	drugs/both), recovering (i.e., reducing, rehabilitating, recovered). Thus the concept of progression – and accessing progression options – is central to our understanding of the type of service needed to make the journey to recovery. The Service Development Plan prepared by the LDTF in Canal Communities envisages progression as including: • Job skills training • Links with partnership employment services programmes • FAS quota of places on	men, single women, mothers with children, couples with children). 2. Admission and intake procedures will place high priority on the group and its capacity to work effectively and therapeutically as a group. 3. Ability to work as part of a cohesive group is crucial to the rehab process.	plan methodologies need to be linked together and reviewed regularly to ensure that the person receives all the supports needed for their recovery and rehabilitation. *Group Work:* Well known that group processes are an integral part of rehab processes wherein people find both support and supportive challenge from their peers. For this reason, proposed rehab service will give high priority to establishing and developing groups of clients which can work effectively to support each others' journey towards rehabilitation. *Performance Monitoring System:* Integral part of service, to monitor and record the			

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	mainstream programmes • VEC quota of places on mainstream programmes. The concept of progression implies that every drug user will require a unique, tailor-made pathway which draws upon all services available including: • treatment, • personal development though group work and counselling, • training, • education, • work experience and placement in employment. This understanding of the drug rehab process means	Groups could be differenti ated by gender, parenting , drug using status etc. *Cost of Programme:* €201,365.	performance of each service participant throughout rehab process. Will record information in following categories: • Age, gender, marital and parenting status, other demographic characteristics. • Main presenting problems. • Status of drug use. • Health status indicators. • Diet and lifestyle indicators. • Accommodation arrangements. • Motivation and self-esteem. • Personal and social skills. • Level of education and qualifications. • Work and employment experience • Involvement in crime. • Family and			

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	that case management and care plans are crucial ingredients in any programme.		parenting relationships. • Involvement and support of families. • Peer and community supports for rehabilitation. • Uptake of referrals and usage of health and social services. • Attendance and punctuality. • Drop out due to disinterest, prison or death. *Follow-Up Studies:* Will be carried out to test durability of rehab after service participants have left the programme for six months or more. This analysis, largely statistical in nature, will be supplemented by case studies to illustrate qualitative outcomes achieved by service.			
CARP	*Aims :*To		Adopting a harm	Semi-structured	*Issues with Funding:* In relation to funding, the	*and Sponsoring:*

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Killinarden Evaluation Report, 1997 *Author* Matt Bowden *Name of Programme:* Community Addiction Response Programme (CARP) Killinarden (1997)	normalize the drug issue and to create a rational community response; To establish a methadone prescribing service and a support service to drug users in advance of the establishment of a statutory service in the area; To normalize drug users and to reinforce and support them in their roles as mothers, fathers, sons, daughters, brothers, sisters, partners; In relation to treatment goals, the programme aims to create physical/biological stability and hence to enable	*Target group*: Local drug users originally treated in Central Dublin, to prevent "leakage" of methadone. *Cost of programme.* CARP has no funding of its own and could not subsidize the costs of medical fees or prescription fees. One year after the service was established, the EHB agreed to provide funding of £25,000 for 1996. Each	reduction philosophy that acknowledges that drug use is unlikely to disappear, the CARP Programme evolved a specifically holistic approach, which caters for the needs of the drug user, the drug user's family and the community itself. *Treatment:* The key treatment tool in CARP is the provision of methadone maintenance. The dosages tend to be relatively high. Equilibrium is reached based on a medial assessment and upon what the participant feels he or she requires in order to stabilize. This is a negotiated process and stands in contradistinction to other treatment approaches that operate on the basis	interviews were conducted with participants of the service. The interviews focused on what participants determined to be the issues and outcomes for themselves. *Benefits of the programme: Generating Awareness:* key benefit of CARP for some is that once stabilized they develop a 'critique' or an awareness of the social relations of heroin use. Moreover, chemical stability plus contact with the programme gave participants the ability to resist heroin. *Awareness of consequences:* Participants	relationship with the EHB has been problematic. There was no response to initial requests for funding. CARP decided to become involved in political lobbying to speed up their application. *Issues with Screening Process (urinalysis):* The screening (analysis of urine samples) process put in place in the early stages was counterproductive i.e., the sample-result time took 12 days. Initially, the taking of samples posed logistical difficulties in that the CARP premises were not entirely conducive to such practices. Also, there were philosophical and ethical difficulties which both participants and volunteers had to overcome in taking the supervised urine samples. CARP wrote to the Director of the Drug Treatment Board at Trinity Court requesting the provision of a speedier testing service. A month later the request was refused. Following liaison with staff at the laboratory in relation to particular results a better system evolved. In addition, the process evolved in such a way that the laboratory began to provide bags and bottles for the purpose. Since this evolved the relationship between the programme and the lab has been constructive and business-like. *Issues with Prescribing Methadone:* Thirdly, the programme had to find a way of ensuring that prescribed methadone was taken as it was intended and that building up or selling of surpluses did not occur. A decision was taken to have a system of 'honest brokering' where a concerned other would act as sponsor to the participant. The sponsor would act as a person to collect and administer the methadone at agreed times, and would play the role of a contact person or support within the community. Sponsors	Participants who availed of a voluntary counsellor were very satisfied with this service. Participants generally reported positively on the sponsor system. At times this gave them much needed support. This is an area which should be maintained, and developed. *Realizing Objectives:* CARP has moved towards realizing some of its objectives. Interviews with participants reveal that they are stable and can engage in relationships in their families and their communities in a less problematic way. By using key local supports as sponsors, the CARP programme has made a significant contribution towards normalizing drug users and this process should be strengthened and developed. *The Local Drugs Task Force:* Interviews with

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	participants to achieve social and economic stability. Key Objectives To provide support to families of drug users and assist in establishing a self directing group for parents of drug users; To provide additional support in the form of counselling, group meetings and social activities; To provide a space within which a medical doctor can have access to patients from Killinarden; To provide, for those seeking treatment, access to a medical	draw down of funds allocated has been preceded by political lobbying.	of a prescribed order in which participants must adhere to strict medial regime in relation to dosages and treatment policies. Treatment in CARP, assumes that the participant of the service takes responsibility for achieving some stability in chemical / biological terms by accepting to remain free of substances other than methadone. The participant is then given the opportunity to achieve social stability in what is intended to be both a 'grounded' and 'culturally appropriate' context. The doctor's treatment programme rests on the assumption that social stabilization is a generic task and can be performed by non-	generally viewed the programme in positive terms and were clear that it had rid them of the need and compulsion to get money to buy drugs. Moreover, it enabled them to look closer at the consequences of their behaviour. Others mentioned more communication with their children. Openness and flexibility of service Those interviewed all reported they had initial difficulty in stabilizing. The openness and renegotiation of dosage with their doctors proved favourable with participants. Achieving a	were typically nominated by the participant wishing to join the programme. In some cases, members of the participant's family would act as sponsor. These have been a critical and essential resource to CARP and have given it a unique character. Sponsors maintain a link with the programme as required and must attend a monthly meeting. *Organizational Developments:* As the programme began to develop and to gather resources and funding from outside, the role of the team had become less clear. The team's role in setting staffing policy in relation to the design of job descriptions and related recruitment tasks did not develop evenly with the new staffing responsibilities it had. Moreover, with the appointment of additional workers who would act as supports to participants or to undertake administrative and secretarial responsibilities, the role of the team vis-à-vis participants became more removed. This left the team members feeling anxious and tense about their position. As such, CARP as an organisation had reached a crisis point during summer 1997. This has largely to do with the absence of an objective view of where the organisation had been going or without the benefit of a facilitator to help the team, the doctor and the co-ordinator to reconceptualise their roles. In addition, CARP as an organisation does not have a set of agreed objectives, a vision or a shared philosophy and as such has largely been driven by the need to complete one main task – the establishment of a service to prescribe methadone to drug users who require it. The team lost is initial function when staff began to be appointed. Many of the decisions taken by	various agencies in the Tallaght area indicated to the evaluator that CARP has been an effective broker in relation to the development of services and responses. It has been a strategic player and a key contributor to the Tallaght Local Drugs Task Force. It has been effective in winning recognition for the local neighbourhood approach which is central to the strategy of the Tallaght Service Development Plan. The point of delivery of the service s crucial – i.e. at the point of residence. This has allowed CARP to remain close to the social context in which drug use occurs. Access to the CARP programme is a crucial first step for drug users as a group of people who experience social exclusion, even within their own community. In addition, CARP is an

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	doctor for methadone maintenance and detoxification; To secure premises for the service and for the future development of CARP – Killinarden. *How define rehab:* In adopting as its core the provision of methadone maintenance, the CARP programme essentially adopted a harm reduction approach to the drug issue in their area. The provision of methadone maintenance by a physician based in the local community would then act as		clinical staff. More appropriately, local people from the participant's own social and cultural context are the mediators of 'grounded' rehabilitation. Thus, a key assumption in the CARP approach is that participants will reach a stage of satisfaction with the dosage they are on. Some will remain at this level. Others will decide to reduce or to eventually abstain and CARP is also available to the participant once he or she decides to 'give it up'. Community Health Approach CARP is an experiment in locally grounded health promotion.	sense of normality Interestingly, many of the participants on the CARP programme are able to access work while being maintained on methadone. Participants for the most part indicated that they wanted to 'be normal', 'get a job', 'independence', 'get a car on the road and get work'. *Financial aspects:* Being on the CARP programme was also seen as being cost effective by some albeit that paying for the service and for the methadone was viewed negatively. The	staff were taken in the absence of a group responsible for setting organizational goals, objectives, policies, and procedures. In sum, the development of the programme and that of the organizational structures and roles have not been moving at the same pace. Many organizations go through similar development cycles and CARP is by no means unique in this regard. *Organizational Direction:* Those consulted by the evaluator felt that there was a need for clearer lines of accountability within CARP. The key disadvantage expressed by team members was the blurring of lines of accountability. Some of those interviewed felt that there was a need to incorporate the views of everybody involved including those who use the service, the doctor, the staff, the community, the stage agencies, the Tallaght Partnership and independent people. As such, a structure has to be found that can allow the staff to get on with carrying out their duties and to enable them work constructively and creatively and at the same time have a forum in which to agree a vision, to set goals and to work together to meet these. Those involved in CARP have given rise to a new way of dealing with the drug problem and the model adopted raises major questions for how drug use is tackled at community level. *Criticisms of the CARP Programme (Participants' Perspective)* *Financial Aspects:* Service should be available to those who could not afford to pay. Some parents have had to use their income to subsidize the methadone. Those	interesting development in the way it has demystified the medical treatment of drug use. The availability of a doctor who can access and prescribe appropriate dosages of methadone outside of an enclosed medical hierarchy is a great challenge to the participants, the local community and to the institutions of medicine. Intervention at community level has been effective in the CARP programme. CARP has developed by working outside of the policy context. To utilize this experience and to explore a new context for policy and practice, the Government should consider the establishment of a monitored 3 year pilot project to develop a new community based model for effective intervention in relation to concentrated, problematic

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	a means of reducing the harm caused to individuals, families and to communities. Methadone, as a substitute chemical allows the drug user to reduce and to control craving for heroin. As such, it reduces the compulsion to steal or to engage in an endless chase for cash to buy black market heroin. It is assumed that this imposes order on a potentially chaotic situation. 'Our philosophy is to walk with people as they move from a life dominated by drugs to a life dominated by the normal cares and concerns… The medical model			cost of being maintained was seen by some as a net saving and as they did not have to get extra money there was no incentive to steal.	who are dependent upon social welfare payments are in a vulnerable position given the pressure placed on weekly household income. Service users had to resort to borrowing from their extended families which would be repaid from the refund. *Concerns about Confidentiality:* The issue of most concern was that of confidentiality. There was potential for other people using the centre and members of Killinarden Action Against Drugs (KAAD) to 'know more that they need to'. There is the potential for personal information in relation to urine results or general performance on the programme to be leaked and used in another context. This is a crucial contradiction of the CARP programme. It is caught in a tension between trying to maintain participant confidence in the programme and ensuring confidentiality so as knowledge is not used as power against particular individuals. The potential exists for power to be used against them and that CARP may in some way contribute to this. This has to be a developmental priority for the programme in the future in that to maintain the confidence of drug users it has to make safe the space they use. *Contradictions:* Posters that were made with the assistance of a contracted arts group were used in anti-drug pusher marches without the participants' consent. *Needs and Gaps in the Service:* Users of the services were unequivocal in suggesting that being involved in CARP should mean more in terms of their participation, for example by involving them in a wider range of activities and consulting them in relation to programme planning. There was a sense that turning	drug use.

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	that we follow on the programme is high dosage and long detoxes as well as maintenance. We would argue that once a person settles on methadone – a highly addictive drug – that the 'chase' is now gone from their lives – that the other problems that they refused to face or weren't able to face now surface and they have to deal with them. To suggest that they should deal with personal and psychological problems while at the same time doing a detox is contradictory to our minds. Medical research also suggests that after one year 90% of people				up and giving urine samples was at best offering very little or at worst seen as being a form of surveillance. *Gender Specific Issues Identified:* Women drug users interviewed felt that it was important for the programme to consider the role that they play as mothers / carers and as such for them to effectively participate in a crèche would be useful. Women participants expressed anger in interviews with the policy of statutory services, that if they were pregnant they would have to travel daily to attend Trinity Court for a lower dose methadone programme. This was seen as disruptive of family life and tiring for women in that they would have to take a long bus journey on a daily basis. (Essentially, a policy exists whereby pregnant drug users are referred to central services. This has the net effect of debarring them from participation in community programmes such as CARP.) *Weekly Group Meeting:* There were mixed views expressed in relation to the weekly group meeting. Some felt it was very difficult to establish trust between participants and as such felt it hard to participate. Others who have stuck with the group are much happier with it now in that there have been some recreational and creative activities which seemed to reinforce the group. *Participant Recommendations:* In interviews participants identified a range of interventions which they felt would provide them with additional supports including counselling, training, education, advocacy, family support, recreation and creative activities.	

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	who have done detoxes are back using heroin. Our community based response to drug use…' (O'Brien, 1996) acknowledges that.				Service participants also want more from CARP in terms of social, educational and vocational development. The normalization process is undermined given that participants have fears about the role which some community activists play in the area and do not favour them being too close to the programme. *Conclusion:* On the basis that participants of the service have raised concerns in relation to confidentiality, the programme needs to reconsider its role in relation to the local community. This might require restructuring CARP as an organisation. CARP has yet to be successful in breaking the 'methadone as cure' myth as perceived in the local community. A more thorough analysis of health and social gains to be derived from initiatives such as CARP would be a welcome step in developing new cost effective, democratically run and community focused health interventions. Investment is requirement in this new treatment sector in terms of management training, research and programme development.	
Opiate	Integrated	*No. of Clients:*	*CARP Services*:	*Qualitative*	*Judgmental Community Response:* Despite the high	*Successful elements:*

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Users and the Child Support Function: An Evaluation of a CARP – Killinarden Project *Author:* Coinneach Shanks, 2000. Second evaluation of CARP-Killinarden (first in 1997).	approach predicated upon fact that children of opiate users are subject to increased risk in comparison with children of similar age. At risk of: • Psychological damage/mental health problems • Physical neglect/health problems • Deteriorating family dynamics • Pressure to undertake care function within the family • Poor educational performance • Crime and delinquenc	Currently dealing with 91 adult clients (one fifth female) and 57 children between ages of 1 and 14 years. *Target Group:* Opiate users and children of opiate users.	• Community methadone clinic in heart of locality. • Drop-in which extends cheerful support and encouragement. • Information, advice and counselling for drug users. • Administration of urine testing in a non judgmental environment. • Access at local level. • Co-ordination of parents and voluntary sector activists through informal and formal networking. CARP seeks to accept its clients as citizens with equal rights and as such does not necessarily display a "goodness of fit" with community values – although it may prove	*Measures of key analytical factors proposed in original research brief (choice voice access and accountability).* *Specific Questions:* • Do participants view involvement of agencies as integrated or totally separated? • Do participants feel agencies work together with them on their behalf or are they considered a source of interference.? • What guidelines or protocols should be followed by CARP and other	level of community-based services, outstanding issues remain for the CARP project and others. There continues to be a community response to drug users, which is structured by moral panic rather than considered reasoning. *Inadequate Premises:* • Space for children current accommodation is limited. Whilst children appear relaxed in this (portacabin) environment, little space to play or be diverted. Can result in children running into the toilets and on occasions, playing with condoms. • Children may see sample bottles being passed between parents and staff. This is thought to lower the status of parents in the children's eyes. • Clients who are in difficulty can appear a bit "groveling" or subservient, losing authority in front of their children. • There are no child-changing facilities in the building. • Recommend an additional linked portacabin. *Initial Children's Bus Problems:* Initial problems arose due to its popularity. Children outside client group wanted to play and found it difficult to understand why they were prevented. Children within client group also found it difficult to understand why they could not bring their friends on the bus to play. When explaining to child clients, bus workers, parents and grandparents tend to describe the bus as a *club*. The suggested "exclusivity" appears to provide a satisfactory explanation for the children and the problem has diminished. *Recommendations for children:*	• Harm reduction approach. • Relaxed staff style and extensive level of informal connections. • Organic relationship with community. *Drop-in Service:* Provides very effective community access to opiate users and families. *Trust:* High level of trust between CARP and clients. CARP makes every effort to be accountable in all its areas. Exercises judicious constructive control over confidential information and information-sharing in best interests of clients. *Conclusion:* A gradual approach to detoxification procedures combined with a tolerance or acknowledgement of the likelihood of failure for the client has produced an apparently stable client caseload who have given

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	y • Having drug or addiction problems • Being taken into care • Accommodation difficulties or homelessness • Poor future employment prospects • Future (inter-generational) family problems. It is important to recognize that in some cases, problems may *not* necessarily result. On the other hand, these areas are not mutually exclusive and multi-problems		an instrumental force in changing those values. *Play Facilities:* Play facilities for children are located in a double-decker bus in adjacent car park two afternoons per week. Provided on an agency basis by the Tallaght Unemployed Workers Centre and fulfils several functions: • Structured play activities. • Children within easy reach of CARP centre. • Observation of children may reveal problems requiring attention. • Children do not have to share toilet facilities with parents who may be required to give a urine sample. • Parents are able to access medical,	agencies in discussing clients? • What development is both appropriate and necessary such that CARP fulfils and extends its service within Killinarden?	• The provision of a corner (in CARP project centre) for children, such as that available in many doctors' surgeries, although space is severely limited. • Provision of a dedicated crèche that demands staffing and adherence to statutory child care regulations. • Provision of a part-time crèche for parents who drop-in (i.e., remain on the premises) would have much to offer parents and children. This would also offer a focus for health professionals such as dieticians, midwives and welfare workers who can then see parent and child together. *Access:* • Limited disability access. • Organisation needs to develop its drop in function without compromising other elements of the service. • Organisation needs to consider permanent or semi-permanent provision for children including crèche or playgroup options. • Review of referral system required. *Choice:* • Elements of choice can be increased by careful expansion. • Extension of resources and facilities for opiate users and children should be considered. *Voice:* • Client group demands special measures to ensure participation. • Voice of children is necessarily limited and participation is constrained by statutory	up heroin and whose methadone dependence is gradually decreasing. In addition to obtaining prescriptions locally, the opiate user is now able to access counselling services and ancillary activities such as aromatherapy and so on. The children of client drug users can avail of play facilities such as a Playbus, attend local activities through Barnardos Lorien project and treatment through the Lucena Clinic. The evaluation must acknowledge that whilst CARP is providing a *service* in the traditional sense, it is also a vehicle for change. *Conclusion:* Despite difficulties, the CARP childcare function has developed very well at the informal level. CARP has also succeeded in dealing with local level problems in an interactive and developmental

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	may result. Additionally, resulting problems are not restricted to the individual. They may affect his or her peer group, school classes and create problems for the neighbourhoods and communities within which the affected individuals live. Furthermore, although the child care function is directed towards the welfare of the child, the CARP project feels that children's activities increase the efficiency of its		counselling and other services without their children present. • Parents can go shopping or merely take a break from child care facilities. Children clearly like the bus and find it accessible. *Barnardos Provision:* Programme of classes operated on behalf of children referred by CARP project. One child who was not happy to be associated with the *name* of Barnardo was eventually relocated in a "teenager" project. This highlights the need for careful labeling and awareness of the outside appearance of young people projects. CARP may find it useful to develop opportunities		regulations. • No means of expression for children as yet. Organisation needs to develop a way in which the voice of the children can be integrated into the project. • Parents could be more involved in project practice despite chaotic disposition. • Similar projects may be able to offer guidelines. In particular, the independent children's rights movement may be able to offer experience and opportunities. • Those parents recovering or recovered could be involved at the voluntary level. *Accountability:* • Accountability constrained by community attitudes and likely condition of the client group. • Accountability for child care function tends to be partially delegated to contracting agencies. • Logging procedures in place but information difficult to interrogate. • Opportunities exist for increasing accountability within the network structure. • Continuous assessment procedures require development. • Organisation needs to review and adapt management structure. • Assessment for children necessary to monitor improvements. *Recommendation for Quantitative Assessment:* Consultant recommends adoption of a quantitative assessment system using qualitative anchor points. It must be *internally* coherent (and theoretically *defensible)* and apply to all within the scope of the	manner. The organic nature of the project is a key area of success for CARP. In particular, its relationship with the parents group has helped to raise awareness in the area of opiate abuse and has clearly proved instrumental in "calming" the community.

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	methadone programme. The placing of children within a safe environment allows the parents some respite from child care and reduces the proximity of activities aimed at the opiate user. In this way, CARP programme tackles problems not merely at the level of individual, but at family and societal level. As such CARP aims to be both curative and preventative.		for older children. *Access to CARP for parent and child:* Local access to centrally located premises ensures availability and ease of use. Services for children increase likelihood of successful client outcomes. Drop-in availability ensures continuation of access and promotes organic relationship *Staff style:* relaxed, approachable for both children and parents (including contracting agencies). Referral system varies for both children and adults. *Choice:* One of several projects in the area so choice increased for clients. Provision of children'x services increases client opportunities for		CARP project. *Follow-Up and Tracking:* Lack of follow-up information may eventually hamper the CARP project. A senior psychologist stressed the importance of outcome information in sustaining the project itself (e.g., there are no long-term statistics for ex clients). Did they succeed in maintaining their "drug free" position for example? Does any recidivistic behaviour exist? It is therefore **recommended that CARP explore, with other local agencies, the possibility of launching follow-up studies.** Follow up studies would gather information in as systematic way using cross-sectional data (or "snapshots") at periodic intervals. Individual organizations can through the design, assess their own projects whilst overall data will lend context to information. The somewhat painstaking task of locating ex clients is, in itself, a worthwhile exercise in data collection. *Conclusion:* The opiate-using client group, the shape of the project and its structural position within drug use services gives rises to inherent difficulties. *Recommend (Child Monitoring System):*CARP needs to improve work with children such that there is more control or management of the system. In particular it needs to monitor more adequately the improvement of children from initial entry through to closure. This report therefore **recommends** the introduction of a monitoring procedure that avoids excessive intrusion, yet provides the project with more knowledge about its work. *Summary of recommendations:*	

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			detox, employment, development. Offers a "different" harm reduction and arms-length approach for parents as additional option within the locality. *Accountability:* Maintained through informal mechanisms and close working relationships with partner agencies. Tends to be dominated by accountability to funder. The category of accountability is a difficult one for CARP – both as a local organisation and as a drug agency. Elements within the community – particularly some of those who use the community centre – were originally opposed to the project's location and although partially resolved, some residual antagonism		• Consolidation of formal data collection. • Pre and post programme assessment of children. • Development of client or "post client" participation. • Development of choice *within* the project. • Codes of conduct and information-sharing. • Publicity and dissemination. *Recommendation (Management Extension):* In general, the management of the organisation could be extended to be more comprehensive. That is, clients, community and funders could be more closely linked at the level of operations and policy. *Recommendation (CARP operations):* • Additional staff resources for supervision, and the day-to-day project administration. • Extend work with children and families. • Current worker receives extra training and additional staff support in following areas: • Intensity contact with children in care of the project. • Supervise more closely the work of contract agencies. • Intensify contact with parents and children *together*. • Generate new areas within which the children can receive remedial services. • Give children some measure of *voice* in line with UN charter on children's rights. • Create and administer adequate monitoring arrangements such that improvements can be recorded, trends established and funds secured. • Introduce an outreach function to ensure that home visits can be made and which will contribute to an	

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			exists. Information gathered demonstrates that CARP operates at a highly principled and responsible level. In turn, clients interviewed show a high degree of trust and reciprocate the responsibility adopted by CARP. CARP demonstrates an awareness of the limits of confidentiality, for example. Looking at information-sharing, it is clear that the nature of the relationship between accountability and confidentiality is dominated by power. The CARP project has shown that this inherent power relationship can be exercised judiciously, constructively and in the best interest of its clients. *Aspects of Drop-in*		efficient flow of clients. • Institute child protection training and procedures. *Recommendation (Child and Therapy):* • No counselling service operates for the children, a lack within holistic service. Information gathered, suggested that some children were receiving different types of counselling from different organizations. Inter-agency cooperation is vital in this area. EHB social workers or the Lucena Clinic may be of some assistance in this matter. • **It is recommended that the CARP counselling service extends to include child and/or family counselling.** • Additionally, the counselling room currently available is unsuitable. The room should be comfortable, quiet and free from distraction or interruption. *Recommendation (New Project Worker):* Recommended that CARP employs a Project Worker to undertake: • Attracting community based volunteers. • Engaging ex client volunteers. • Building a volunteer team. • Conducting volunteer training. • Developing peer education. • Drop in work. *Note:* In accommodating these staff changes, little adjustment is needed in the *style* of operation. The objective is to reinforce the current operation, consolidate success, plug "gaps" and extend family support services.	

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			*Work: s*taff style based on personal warmth and openness, all staff members display a general and unconditional interest in clients and their children; non-judgmental approach that recognizes that opiate use is only one of many elements in a client's life; recognition that clients require assistance in key areas such as health and employment; acceptance of client failure and a willingness to help clients try again; close working relationship with local community activists and agencies and an organic relationship to the locality in which staff work. *"Choice" and the CARP Project:* It is important to the		*Recommend (Greater Publicity):* Recommended that CARP devotes resources to publicizing the project in the areas of: • Social work • Penal institutions • Child psychology • Education psychology • Drug education (e.g. the intervention of CARP could prove extremely useful to community drug awareness programmes. In so doing, the project can assist in altering attitudes to drug users.) *Recommend (Managerial and operational system):* co-ordinator requires more space to develop policy, mobilize funding and extend networking. Recommends additional staff training in area of child support and protection; review of the administrative function which allows for efficient administration *and* core work within drop in function; an extension of counselling function into child and family work (i.e. additional sessional counsellors are recommended). *Recommend (Volunteer Activities):* The appointment of a project worker to take over some of coordinator's existing responsibilities, whilst developing and increasing volunteer capacity, peer education, etc. *Recommendation (Management structure):* Revisions to management structure recommended whilst retaining the current "flat" structure. *Recommendation (Information sharing):* CARP and associated agencies such as Barnardos, schools, etc have evolved effective information-sharing at the level of practice, formal collaboration and informal	

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			project that clients choose to enter the programme of their own volition. There are conditions applied to clients once they are receiving a methadone script and the clients must agree to the terms of the project regarding urine samples, etc. *CARP Ethos:* To allow for dignity and respect. Taking someone off the programme because they are *suspected* of misdemeanors (e.g. stockpiling methadone at children's risk) offers the following dangers: • Client no longer accessing a mainstream programme. • May seek to return to subcultural activity. • His or her children are "out		networking. Recommend that: • CARP adopt own code of practice concerning confidentiality and information sharing. • Clarify, for its clients, the boundaries of realistic confidentiality. *Recommendation (Assessment System):* Consultant recommends construction of an assessment system for clients, which engages with the spirit and ethos of the project.	

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			of sight" of community professionals. • Real danger of worsening adverse affects on children of the opiate users. Observation reveals that CARP staff take all reasonable precautions and measures to ensure conformity with the agreements made with clients. It is in this way that CARP through a relatively hands-off approach, achieves respect and credibility amongst clients. *Voice and the CARP Programme:* Because of delicate position of project, opportunity for clients to comment and to effect change is limited. Opiate users' lead somewhat chaotic lives and there is no formal			

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			mechanism through which opiate users can become involved in the development of the project, although several opiate users have become engaged in drug forums, newsletter production and web page design. This is an area which should be developed. The voice of the children must also be taken into account. This is harder to organize and requires facilitation. *Monitoring:* Although CARP keeps records on individual clients, basic statistical information is needed on the status and development of clients and children. This problem of data *storage* as opposed to data *retrieval* is a typical problem for practically orientated projects. Funding			

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			agencies require information that gauges the effectiveness of the programme and the project itself requires data analysis that measures client and project outcomes. Project data is, however, systematic and neatly displayed. Information on children suffers from similar problems. Little attempt is made to assess children since this is, in general, left to the agency to which the work is contracted. It is therefore difficult to determine the effectiveness of the child care function apart from consumer satisfaction (which is, nonetheless, considerable) of parents, grandparents and the children themselves and confirmation by teachers that children			

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			using CARP services have improved. This case also gives rise to problems of confidentiality. Teachers will not necessarily know which children are using the services of the CARP project and the question of whether they *should* know is arguable. *Drop-In:* The drop-in features of the CARP project work well. All staff members combine to promote this function and this gives CARP building a sense of welcome, cohesion and solidarity.			
Evaluation of the Coolamber Programme, December 2004. *Author*	*Aims:* The programme sets out to integrate therapeutic, life skills, nationally recognized vocational programmes,	*No. of Clients:* Target was 20 existing addiction treatment service users with an established history of recovery, this	*Duration:* One of the unique features of Coolamber that differentiate it from other residential progammes within the scope of addiction services is precisely its duration.	*Programme Outcomes:* Programme outcomes were very positive for trainees. • All trainees achieved vocational qualifications.	*Poor Liaison With Service Providers:* Liaison with service providers (including health boards) is very poor and unstructured. There is no evidence of adequate communication structures to allow integration between Coolamber with other services to facilitate effective case management of trainees. Once a client of the health board has entered Coolamber, there is little to show follow-up on behalf of RCO's or key workers involved in prior care/service provision. Neither is there evidence to support progress reporting to such	• *Programme length:* (over a third of trainees cited length of programme as a significant motivation for joining it). • *Programme staff:* (the staff's commitment and dedication was

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Dept of Community, Rural and Gaeltacht Affairs/ NTDI/QE[5] *Name of Programme:* Coolamber Programme Department of Health (2004)	and educational supports in a holistic residential environment, with a view to developing and maintaining independent living, employment or further study and reducing/ending substance misuse, recidivism and health issues associated with substance misuse. *How define rehab:* Describe vocational rehab programmes for drug dependant persons as typically including assessment of individual	however was unrealistic (i.e. occupancy rate 54% against a target of 85%). *Target Group:* Coolamber is a drug and alcohol free, residential and vocational rehabilitative training programme for individuals with a history of substance misuse (referred to as trainees). *Cost of Programme:* €2.7 million *How long in operation:* Established in 2002.	Twelve month programme which is delivered in four stages: 1. Initial health board client assessment and referral through support agencies. 2. On site assessment for two weeks (induction phase) to determine participant suitability for the program. 3. An independent program plan for each participant based on an individual training needs analysis. 4. Training, leading to educational qualifications or certification in specific areas (e.g. horticulture, equestrian studies, agriculture, IT, hotel hospitality and	The average number of individual achievements in relation to qualifications was six. • 67% of those who remained on the programme beyond six months progressed to full or part time employment and/or further education and training. • Those who completed their programme were over three times more likely to enter into employment and/or further training than those who left pre-completion. In contrast, those who left the programme early were over	key workers on the part of programme staff. Where such communication was noted in the client file audit, it was in instances where trainees had relapsed, or at increased risk of relapse, and services were coordinated in a reactive way to address the issue. *Limitations with Referrals:* • Referrals to the programme were slow from the outset, with intake peaking in November 2003 at only 80% capacity. • Rehabilitation Co-ordinator involvement across the health board areas appears to have been limited. No evidence of follow-up on client progress from addiction services. *Programme Role Confusion:* • There is confusion around the exact role and remit of the programme between service providers within health board areas and programme staff. It was regarded as a solely vocational programme by some providers, with no/limited therapeutic input, which may have affected referrals made at the outset. • There is no evidence of a formal assessment process on the part of Rehabilitation co-ordinators, therefore no indication as to the basis against which suitability was defined, or data in relation to the number of referrals made to RCO, which were deemed unsuitable, and reasons for decisions. • There is also inconsistency in relation to eligibility criteria – the initial agreement between NDTI and ERHA specified that trainees must be aged 18 and over, whilst the Coolamber website states that anyone over 16 is eligible.	praised, although 'initially staff weren't experienced enough and trainees got away with murder'). • : High level of client satisfaction with the one-to-one counselling services available at Coolamber (although group support not as highly regarded). • *Programme Completion:* 15 trainees (75%) completed or approximated completion of their designated programme. All completed programmes were for the 12-month duration. *Current Status of Trainees:* • Two in three had progressed to further education (30%) or employment (30%). This feedback indicates that successful completion

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	vocational needs, counselling, skills training and job placement. Residential rehab refers to all programmes that include detoxification, maintenance and, finally, abstinence within a residential setting. Residential rehab involves communal living with other drug misusers in recovery, group and individual relapse prevention counselling, individual key working, improving skills for daily living, training and vocational		accommodation). Other modules include personal development and creative skills, which also carry certification. Assistance with identification of career paths and tackling potential barriers to employment. Throughout the programme educational supports, in areas such as literacy and numeracy are available, with psychological supports from full-time counsellors. There is also a comprehensive leisure program comprising supervised social outings and activities such as IT, art, horses, gym, project work, football, basketball, music, drama, adult literacy	three times more likely to relapse into addiction. • The social impact on trainees, including those who left pre-completion, has been positive overall. All reported having benefited to some degree from participation on the programme. Furthermore, the high completion rate is all the more significant given the early school leaving ages of trainees, lack of vocational experience, and previous attempts in alternative treatment options. It could be argued that, for this particular profile	*Lapses in Urinalysis:* • Despite a clear policy on consistent urinalysis across randomly selected trainees, there was nothing to support the practice of random testing in the client files audited. This is of significance due to relapses of trainees (documented by staff) whilst on the programme, and impact of this on other trainees. *Poor Programme Documentation:* • Programme documentation (mostly paper-based and stored in separate areas) does not facilitate integration or analysis, which limit the value of information for overall programme analysis and development. *Limited Staff: Client Ratio:* • The insufficiency of trainees placed in Coolamber throughout the programme has created inefficiencies in service delivery, and a clear impracticality in the current situation (at time of evaluation 8.5 staff to each client). *Reporting Structures:* • There is no evidence to show that this aspect of the project was implemented in an effective and efficient manner. They have produced updates and internal evaluations but the lack of monitoring and evaluation by the funding body is a weakness. The absence of a project management committee may have contributed to this. *Retention of Trainees* • Only 11 (38%) of trainees recruited to Coolamber completed their programme.	of the programme in relation to progression to employment or further education/training denotes improved economic status of trainees). *Positive Aspects of Programme:* • One in four trainees reported the environment and atmosphere were the aspects they enjoyed most, while one in five cited the vocational training as the most positive feature. • Other answers revolved around trainees re-establishing their sense of self-esteem and identity, and gaining confidence. • Almost three in five clients felt certain they would have relapsed had they not availed of the programme. This

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	experience, housing and resettlement services, and aftercare support. Residential rehab deals with treatment within what is commonly referred to as a therapeutic community. A therapeutic community can be described as a drug free environment in which people with addictive problems live together in an organized and structured way to promote change towards a drug-free life in the outside society. *How define rehab:* *Vocational*		and life management. *Progress reports:* Provide quarterly progress report on target group, placement rate, assessment system, training programme, performance indicators, and financial statement. Performance indicators refer to accreditation for every service user who remains with the service for a period of six months gains a minimum of one Fetac (or other relevant) qualification. *Retention:* Quarterly review and a retention rate of less than 60% will trigger a review of referrals and of programme content. *Assessments and Documentation:* The inclusion of	of service user, sustainable rehab is most effective with a multi-faceted approach which promotes vocational rehab. *Programme Occupancy (Target)* • To achieve at least 85% placement target for 20 trainees over 12 months. *Evaluation* • Placement on the programme averaged at 54%. • At its peak (November 2003), occupancy was 80%. • However, virtually all referrals made from RCOs were	*Lack of Guest Speakers* • Clients considered it would have been more interesting and informative to bring in such speakers as ex-addicts, or people who had found themselves in a similar situation to the trainees. *Least Positive Aspects of the Programme (Trainee Perspective):* • Group therapy sessions viewed as least enjoyable aspect of the programme by one in four respondents. Due to a personal discomfort within the group environment. Lack of a cohesive group structure 'too many chiefs and not enough Indians'. • Lack of structured activities at weekends (one in ten respondents). • The distance from family members (particularly trainees with children). • Negativity surrounding rules and procedures – specifically having to ask permission for certain activities, supervision of residents, and the set bedtime. Although the latter was recognized as a necessary evil, 'or we would have taken advantage'. • Problematic issues with a specific member of staff, a Residential Support Worker. Issue surrounded negative comments and "put-downs", often expressed in a sarcastic, joking manner, which trainees felt to be undermining and hurtful. Whilst one individual had made this known to centre management, others (despite requests from management) felt they couldn't due to lack of confidence and fear of reprisal from the individual. Whilst many of the instances described may not be perceived as directly or deliberately abusive, the	included trainees who stated they "would be dead by now" as a result of their drug misuse, or dealing drugs in an effort to raise extra money. • Almost two-thirds (62%) of external stakeholders felt overall programme management to be good, with the overall perception of a well-run programme with committed staff. • One in five staff (22%) highlighted the results on the training side of the programme as self-evident. • Modality of the programme (39%). • Individualized approach of programme for trainees (33%). • External stakeholders view the vocational training aspects of the programme as its key strength. • In contrast, staff perceive the holistic

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	rehab is generally viewed as a reasonable and effective measure enabling drug dependent persons to participate again in regular occupation and in mainstream society. The EUREHA Project (2000) describes vocational rehabilitation programmes for drug dependent persons as typically including: • assessment of individual needs, • counselling • skills training, and • job placement.		handover reports and key issues arising from sessions ensure a seamless integration between the different staff involved in working with trainees, and also assisted in effective operational management and delivery of the programme. *Communication and Reporting:* Communication with Coolamber programme between staff and management, and with current and previous trainees, is of a very high standard. The use of handover reports, and daily staff meetings, ensure clear communication and simplicity in programme operation and management. *Training* Training provision within the Coolamber	converted to placements. *Retention of Trainees (Target)* • That 60% of service users who accept a place after two week induction period remain for a period of at least six months. *Evaluation Findings* • 79% of service users remained for a period of at least six months after the first two weeks. • 63% were recorded as having completed their programme. • The average length of participation on the	emotional and psychological vulnerability of trainees in rehabilitation treatment cannot be ignored, therefore adding significance to the effects of such behaviour. *Suggestions for Improvement (Client Perceptions):* • Almost one in three of those clients interviewed felt that the addition of more training modules would improve the programme (with Mechanics suggested specifically). • One in five trainees felt there is room to improve procedures relating to the programme – in particular, assessment and relapse procedures, and a more structured after care provision. • One in five felt there is a need for more residents on the programme in general, and in relation to female residents specifically. • Improved social activities – including weekend activities and family visits, and greater flexibility in 'house rules'. • Less emphasis on group work – possibly through a gradual phasing in of trainees to group therapy of having this as an optional feature. • Better staff – this referred specifically to the issue highlighted ('put downs'). *Programme Staff and Key Stakeholder Perceptions:* • *Poor Inter-Agency Collaboration:* Almost four in five external stakeholders referred to inadequacies in inter-agency collaboration (77%). This was highlighted in relation to a lack of engagement with external service providers either in the development stages of the programme or in its operational life. There was felt to be no formal communication structures or reporting mechanisms that facilitate interagency communication, a	approach incorporating vocational training with rehab therapy and life skills to be its key strength. • Staff regard the geographical location of the programme as a key strength, removing them from their old location and providing a comfortable, secure environment in which they may address issues surrounding their drug misuse (in contrast to clients). • Almost two in five stakeholders (38%) felt that there had been successes achieved with individuals placed I the Coolamber programme. However, this still emphasizes an external perception of the programme as being almost entirely vocationally focused, which is at odds with the perceptions of

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	Residential rehab refers to all programmes that include: detoxification, maintenance, and finally, abstinence within a residential setting. Residential rehab involves communal living with other drug misusers in recovery, groups and individual relapse prevention counselling, individual key working, improving skills for daily living, training and vocational experience, housing and resettlement services, and aftercare		programme was of a very high standard, both in terms of the range of core modules and additional training and education provided, and in the training outcomes of trainees. By the end of August 2004, a total of 152 qualifications across a wide range of vocational, social and academic areas by trainees. Those who completed their individual programme performed considerably better than their counterparts who left pre-completion. *Exit/After Care:* After care provided was optional and trainee-specific based on individual needs, with one to one counselling sessions offered, telephone contact and informal	programme was eight months. *Accreditation (Target):* • That every service user who remains with the service for a period of six months gains a minimum of at least one Fetac (or equivalent) qualification. *Evaluation Findings* • All service users achieved vocational qualifications. • The average number of individual achievements in relation to qualifications was six (with those leaving pre-	general lack of follow-up or feedback with referrers of trainees, and a sense of geographical isolation due to the centre's location. • A lack of ethos within the NTDI organisation in general in relation to interagency partnerships, and an overall sense of politics limiting such development with agencies and groups 'protecting one's own patch'. This would reflect the common view of external stakeholders consulted. • *Poor Programme Structure:* One in six external stakeholders felt the structure of the Coolamber programme to be poor (16%), with concerns primarily focused on the length of the programme as an effective intervention (it was generally felt to be too long and increased the risk of institutionalization of trainees in an unrealistic environment). • *Issues re Specialist Services:* Staff mentioned difficulties in accessing external specialist supports (e.g. mental health assessment and / or treatment, or specific skills development not offered by the centre), and a lack of flexibility within current structures for development into other areas. • *Poor Programme Content:* Less than two in five external stakeholders (38%) felt the content of the Coolamber programme to be effective or appropriate for the client group served. Almost one in three questioned the appropriateness of the modality of vocational training offered (31%) – specifically in areas such as agriculture and equestrianism – given a client base that is predominantly urban-based. In addition, roughly one in six (15%) felt that, given the inherent risk of institutionalization with a one-year programme, there is inadequate emphasis on transition/'step-	staff and trainees on the programme. • The structure of the programme and tailored approach were identified as key strengths. • Programme content is of a very high standard, and offers a wide range of subjects for trainees. • Against original target of 60% retention (after first two weeks) for at least six months, programme exceeded this on two counts. 79% of trainees remained for a period of at least six months after first two weeks, and 63% were recorded as having completed their programme. • There was also a strong correlation found between success of trainees in certification gained and progression into employment and further

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	support (Audit Commission, 2002).		follow-up and group meetings organized within the latter phase for the programme. There was an excellent standard of communication and reporting internally within the programme. This, however, was not the case in relationships with external stakeholders. There was no established structure for follow-up or feedback; therefore this depended solely on individual relationships between staff and external keyworkers. Additionally, there was inadequate monitoring and reporting by the commissioners (ERHA) against the standards set down within the Service Level Agreement.	completion at least two). • A total of 152 individual qualifications had been achieved by trainees by 1st September 2004, with a further 17 awaiting assessment. *Progression (Target)* • That 70% of participants who remain beyond six months enter into appropriate progression routes, set out as full or part time employment or appropriate further education or training. *Evaluation*	down', and equipping trainees with the adequate life skills to manage on leaving Coolamber. This issue was also raised by over one in five staff consulted (22%). A further one in ten (12%) felt there should be more practical work experience and emphasis placed on modules to prepare trainees for the labour market. • *Exclusion of Methadone Maintenance Clients:* Stakeholders felt that the exclusion of clients on methadone maintenance programmes was a distinct disadvantage. Indeed, research into the literature has shown that persons on drug maintenance have a strong prospect of moving into secure employment. • *Artificial Environment:* Another key weakness perceived by external stakeholders was that of artificial environment created by Coolamber programme (46%). One year in cosseted environment with little preparation for independence and self-sufficiency. • *Issues re Funding:* Staff felt that uncertainty over continued funding as the primary weakness facing the programme. Embargo placed on new entrants to the programme has had a very negative effect on morale within the centre. • *Remote Location:* Because of geographical setting of Coolamber programme, it can be difficult to access external supports for trainees. • *Restrictive Inclusion Criteria:* Intake was limited due to restricted inclusion criteria (established history of recovery), and through an inability on the part of the Coolamber programme to recruit outside of the ERHA catchment area, and the exclusion of persons on methadone maintenance (which stakeholders felt were more suited to the	education/training, supported by the findings of the literature.

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			The lack of appropriate communication and reporting mechanisms on an interagency basis had a notable negative impact on the programme's effectiveness, evidenced in contrasting perceptions of the programme, poor referrals in terms of numbers, and limited knowledge of trainee progression or programme development.	*Findings* • 67% of those who remained on the programme beyond six months progressed to full or part time employment and/or further education or training. • This included 65% of those who completed their individual programme (regardless of time spent on the programme). • In addition, those who completed their programme were over three times more likely to enter into	programme.) • *Lack of Clarity re Service Provision:* In relation to assessment for referral, a lack of clarity and awareness of the service offering provided by Coolamber. Can be principally attributed to a lack of interagency co-operation and communication between programme staff, health board staff, and treatment providers. It would appear that contradicting perceptions in relation to eligibility and service offering have had a considerable negative impact on the programme reaching its potential for the benefit of trainees. • *No Follow-Up/Feedback:* Whilst the initial assessment system operated by Coolamber is good, it uses assessment measures with no evidence of feedback or follow through in developing individual programme plans. It is also felt that this stage of the assessment process should be lengthened to at least six weeks to enable more comprehensive assessment of the holistic needs of the trainees within the areas of addiction/drug misuse, academic and vocational capabilities, and mental and physical health needs. • The importance of aftercare and follow up for trainees was considerably underestimated in the programme's inception, and there is a high risk of institutionalism for trainees. Staff have endeavoured to counteract both these issues through providing step-down accommodation within the centre, and developing an aftercare structure. • *Programme Length:* Programme length is a source of uncertainty (ranged from one year at outset to between four to nine months).	

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				employment and/or further training than those who left pre-completion. • Those who left the programme early were over three times more likely to relapse into addiction.		
Dun Laoghaire Rathdown Rehabilitation Survey: A survey of Client Perspectives in Rehabilitation. *Author:* Mary Doherty,	*Aims:* To conduct a survey of existing service users to determine their level of satisfaction with the existing service. *Secondary aim:* Identify appropriate interventions – from a user's perspective – that could be	*Total number surveyed:* 63 (Oasis Project 6 Participants; Pathfinder Group 7 participants attending current services between 6 months and one year, 3 participants attending current service for more than two years; Satellite Clinics, 7	Provisional questionnaire drafted, including certain demographic characteristics of clients which would have a significant bearing on their views of rehabilitation: • Gender • Age • Length of time attending current service • Accommodation • Education to date • Current employment status • Forensic history • Current physical	*Aids and barriers in Rehab:* *issues* (e.g., counsellors leaving, receiving 'alcoholic' type counselling, fears of repercussions re honest disclosure, inability to trust counsellor. *Methadone maintenance:* (Pathfinders Project) vehemently opposed to maintenance programme: Methadone too freely given out; methadone necessary to function but more damaging than	*Recommendations (Clients):* • Call for a stranded service. The Health Board proposes four categories of clients: unstable, stable, detox and drug-free and recommends different kinds of services most suitable to each stream. Findings indicate that not only service providers make these distinctions. Survey provides support for hypothesis that streamed services would be more effective, and recommend that such services be implemented forthwith. • Services to maintain visible links with one another, so clients can see clear progression through services on offer as stability is attained, maintained and increased. Links should be two-way (back to original treatment centre if	*GP Service:* One consistent outcome was Client satisfaction with GP service, both in clinics and surgeries (observed atmosphere of trust and mutual respect). The GPs have many significant offerings to make to the development of the service and are interacting with clients on a regular one-to-one basis. This must be acknowledged and also utilized. *Ve swiftly*

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Emma Kate Kennedy, May 2000. Commissioned by Dun Laoghaire Rathdown Drug Task Force	included in submissions to the LDTF Service Plan for 2000. *Main aims:* • To establish the demographic profile of those seeking rehabilitation within the Dun Laoghaire Rathdown borough. • To determine implications of this profile for such rehabilitation.	participants, most attending satellite clinics for six months plus; GP Caseload, 11 participants, 50% attending less than one year, 50% attending one year plus).	health *Other measures:* • Aspirations regarding future drug status were also surveyed, along with several items pertaining specifically to rehabilitation. • Qualitative data (client opinion on quality of their accommodation, level of job satisfaction if employed, etc). • Physical health status of clients (4 items in questionnaire). • Social support (7 items in questionnaire on peer, family and partner support). *Background of Services:* *Oasis Project:* (community based rehab project, established Jan-98.) Community employment scheme for drug users: a programme of education; rehab and support, to enable participants to take	heroin; methadone extremely dangerous. *Factors helping clients cope with their drug use:* • Maintenance • Family support • Partner support • service • Employment • Other. *Barriers to Recovery:* • Continued drug use in family • Partners continued use • Lack of supports • Boredom • Unemployment • Proper accommodation • Other: • Friends continuing to use • Their 'moods' • Continued availability of drugs • Lack of self confidence • Other people on the scheme not being stable enough to participate on the scheme	client relapses in rehab). • Advocated smaller, locally based clinics. Exposure to others at various stages of stability (at clinic in Patrick's Street) was detrimental to their own stability and perception was that quite stable users primarily attended the satellite clinics. • That any future rehabilitation programmes be supported by a formal advisory committee. This rehab programme could therefore comprise of a management committee providing the services and an advisory group for this committee. The advisory group could include representations from the Gardai, probation service, childcare, local authority housing, medical profession, social workers from health boards, and funders of the project. • That there be a seamless interface between advisory group, the management committee and the day-to-day management structure. The benefits of such a system are that it responds to the many needs of clients expressed in the research. These needs include: • Multiple levels of support on a variety of issues. • Clear and concise information pertaining to health / social welfare / legal entitlements, etc. • Proactive services which have planned	

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			control of their own lives and their drug use). *Pathfinders Project*: an education and training programme for people in recovery from drug use in greater Dun Laoghaire area (on methadone maintenance), aimed at enabling them to re-enter mainstream society. Programme offers participants computer training, discussion groups, personal development, stress management, job skills club, first aid, leisure days including swimming, bowling, outings etc., group meetings. *Satellite Clinics and GPs*: other two access routes to services.	• within the scheme • Lack of direction within the service. • Maintenance programme was not based around client needs. *Important factors in helping clients stop using:* • • Things to do • Other • Adult education • More clinics • Residential detox • Users support group • Accommodation • Employment *Pathfinder Client Comments:* • Clinics being abused • People are at different stages of rehab, smaller clinics with people at different stages attending on the same days would be better • 5 participants in favour of a user support group "away" from the clinic.	and resourced for as many varied outcomes as possible. • Vital to foster formal and strong links between different services providers to serve the client as efficiently as possible. It is the multi-disciplinary team that works well together and shares information (while maintaining necessary confidentiality) that give the more holistic assistance to recovering drug user. • That allocations group representative of referring workers be set up, including GPs, the counselling service, social workers, outreach workers, community welfare officer and any other relevant agencies. This group would have ongoing input into the selection of clients who would attend any future rehab programme. *Limitations (Clients):* • Clients appear to have overestimated their physical well-being. They have unrealistic perceptions as to how healthy they are. • Recommended that health education play a substantial role in any future rehab programme. One client with hepatitis C commented that she was not sure what the disease was or how to seek treatment. Clients should be made aware and consistently up-dated	

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				Supports needed for a better lifestyle: • Education (of greatest benefit after one year when greater stability) • Training/development (vocationally based) • Childcare • Employment • Family • Other • Accommodation support • Drug awareness, • Information about long-term damage, separate support for families from clinics • More counselling • More exercise • Greater focus on activity • Meeting people who were not in a similar situation would be ideal, as social isolation felt by drug users was a contributing factor in their relapse. *Participant Comments:* 'The social exclusion of	on health promotion practices. Other issues that could be addressed in such a module include: HIV / AIDS, vaccinations, dental health and screening for cervical cancer. *Client Recommendations (Programme Content):* • Holistic approach to client reflected in structuring of programme. • Client sense of ownership and responsibility for the programme facilitated from the outset. • A "menu" of activities made available to clients which they could select and design (with input from their case worker) the rehab course best suited to them. • Mandatory life skills session for each client. • Choice of elective modules. Note: this system allows for the fact that each group that attends the programme has distinct needs and wants. Just because a particular programme worked with one set of clients does not mean that such a programme would be equally successful with another. • Recommended modules: • Nutrition and diet; • Literacy (many illiterate clients). High self-esteem is the backbone of successful rehab and illiteracy threatens this self-esteem. It is crucial that any future rehab programme	

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				every day life is hard to bear, the hiding of everything like clinics and methadone, in the chemists make you feel like a social misfit and a criminal. 'I think it is hard to get people to help you get into treatment. It should be a lot easier.' 'A similar project to Merchants Quay is needed in Dun Laoghaire and more emphasis on counselling is necessary (this client had attempted suicide but is getting no counselling). One Pathfinders client suggested there should be more activities for teenagers (especially after school) as a preventative strategy. 'Clients need help with counselling now – they cannot afford private counselling'. 'Hostility from the public was very damaging'.	addresses this disadvantage with a degree of urgency; • Numeracy; • IT skills; • Social skills; • Parenting skills; • Relaxation training; • Addiction education; • Physical activity; • Art, etc. • Content must include scope for inclusion of partner and extended family and children. • Crucial for any future rehab programmes to build on support systems already in place, rather than compete with these supports. • Adequate childcare provision, parenting and childcare programmes, family groups, co-, user and partner support groups, etc. would meet this need. • Many clients identified boredom as the main barrier in their recovery and employment support as an aid in improving their lifestyle. • General consensus that if client had a job, they would just stop using. This erroneous belief needs to be taken seriously by the service providers. • Clients need to be supported in making realistic self-assessments on their readiness for further training, education and development. • Sample surveyed recognized that they	

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				Would like more information on entitlements, especially social welfare. 'There aren't enough counsellors and the existing system is over-stretched. They are too busy to be effective. Counsellors don't remember previous sessions, there is no continuity between sessions and the client sees no benefits.'	were not attractive in terms of potential employee status. Clients are well aware that their drug use, poor education background, lack of employment experience and possible criminal record all work against them when they decide to seek employment. Client self confidence and self esteem may be damaged by rejections they may receive when seeking employment. • Therefore, recommended that a sheltered employment initiative be established as final phase of recovery for recovering users. Such an initiative would also equip the person with team skills, decision-making and problem-solving skills, assertiveness, communication skills and time management. • *Service:* The service appears to be stretched to capacity, undermanned and limited in resources. Recommended that counselling service be better resourced, expanded and more intensive. • *Drug Free Status:* All clients expressed aspirations towards being drug-free. *Implications For Rehabilitation* *Gender:* No participants on Oasis or Pathfinders scheme mentioned any gender based conflict/problems. Oasis project had positive experience of mixed gender	

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					grouping. Only implication: presence of women on future programmes usually indicates childcare facilities will be needed as standard. *Age:* Very young or very old client (relative to others in group) may feel isolated or a lack of peer support. Important to act as sensitively as possible in this regard and judge each situation on its merits. *Length of time attending current service:* Significant numbers moving through the clinic in Patrick's Street. This may warrant further research to determine exactly where these clients are going. Are they progressing on to a satellite clinic / GP surgery or descending into chaotic drug use and not availing of any service? Length of time attending the current service may have implications for client rehab. There may be different kinds of drugs users – those who move swiftly through the system and those who become static at a certain point (e.g., some attending Patrick's clinic for two years). New clients may also wonder/become frustrated as to why there are people on the same programme for two years. It can also be difficult for new clients to break into the established social order, leading to a sense of isolation on their part.	

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					Accommodation: Majority of sample live in their family home (i.e. family of origin). It follows that rehab that considers the client in isolation is not accepting reality of kinds of situations that clients are in. None of sample volunteered information relating to tensions in family home. Unenviable conditions of some clients are blatantly obvious from the comments made by those who are homeless. Implications for rehab concur with similar research – without proper adequate accommodation clients will be unable to engage in a positive recovery. *Education/Early School Leaving:* Education level of Patrick's Street group is particularly low. Startling figure of 78.5% having left school without relevant certification. *Employment:* Most clients in Patrick's Street are unemployed. .03% of Patrick's Street clinic group are in full-time employment, compared to 90.9% of the GP caseload. There is a massive 85.7% of Patrick's Street clients without any meaningful activity to engage in. In terms of rehab, Patrick's Street group are, relative to others, more chaotic group. Those who have reached a more stable	

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					stage in recovery will be looking forward to the future and will need some form of employment support. Anecdotal evidence would suggest that rehab programmes are most successful when run as a scheme, where clients are receiving payment. The positive attitudes of the Oasis participants towards their attendance on the scheme are an example of this. There are a myriad possible reasons for programme being more successful when participants are paid, all of which necessitate further research. These reasons may include: the boost to self-confidence in terms of "coming off the dole", the increase in self-esteem and self-worth through participating in meaningful engagements during the day and the practical benefits to being so engaged. *Recommendation (Stringent Assessment):* Recommend stringent assessment of clients who wish to attend any future rehab programmes. This assessment must necessarily include input from all of the services that the client is availing of, and must not rely solely on the opinion of one or two individuals. Many rehab programmes have forms of assessment already in place, and liaising with agencies providing these programmes to examine the efficacy of assessment would be worthwhile.	

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					Need for Social Supports: Most clients have no close friends or whose only friends are fellow drug users. Fact that 92.3% of clients had friends in past who were not drug users indicates a massive loss of peer support. Recommend Rehab include life skills / social skills training (even demonstrated through modeling in the form of a buddy system, with established members taking a newcomer "under their wing"). *Need for Childcare Supports/Crèche:* • Provision of a crèche is essential for children under five – operating while parents attend their programme. • Clients who are parents would benefit greatly from advice, help and the development of parenting skills. • The advantages of this are two-fold: children are experiencing quality childcare; and parents are aided in their parenting. • Furthermore, existing childcare provision in both Patrick's Street and the Oasis Project needs to be maintained and further resources. *Service:* Counselling service perceived by clients to be under-resourced and stretched to the maximum. Can thus be queried whether counsellors are physically able to see clients frequently and on an individual basis.	

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ICON Drugs Support Service Evaluation Report October 2002 *Author* Michael Rush *Name of Programme:* Icon Drug Support Service (2002) Note: (difficult to find key information in this report)	*Mission* To provide a practical response to the nature of addiction in the north east inner city of Dublin. To provide immediate support on request to individuals and families whose lives have been compromised by addiction. To create a community service and environment where clients and families are treated with respect and dignity. To provide within the continuum of services a first port of call to which clients	*No. of clients on programme:* Current records show 330 clients between 2000 and 2002. There were more male (168) clients than female clients (121). The majority of clients presenting to the service are in their twenties and thirties. These are long-term addicts. *Target Group:* Open door policy for active drug users, clients receiving prescribed methadone, and post rehabilitation clients who are remaining drug free.	The co-ordinator is the main outreach worker and manager of the service. The Key Worker supports clients in the continuum of services and specialist services and brings to the service a knowledge of services which is highly developed. This member of staff is very well networked into other agencies and also has the trust and respect of the client group. The post involves being the main referral agent and agency liaison link in the service. The key worker and the co-ordinator try to meet first time clients together to agree a support strategy with the client and to ensure that if the client returns then they will be sure to meet someone they know. Both the co-ordinator and the key worker are experienced in assessing the drug or alcohol addiction status of individuals. The service usually refers clients to	*Client Evaluation:* Survey questionnaire distributed to twenty of the clients who had used the service within the last month; completed by 14 clients. *Services Identified by Clients:* Support for clients and then services for families were the shared top priorities for families and clients. The next priorities were referral into or along the specialist addiction services continuum, the provision of emergency support and crisis care and client advocacy or professional services (for example letters and advice). Access to residential care was seen as an important output of the service as was advocacy. *Service Provided:* Support, access, information and assessment.	*Obstacles Facing Clients:* Obstacles facing clients who feel their next step is residential detoxification include; disagreements with their GP over detoxification from methadone or other prescribed drugs, the pre-requirement of being drug-free before entering residential treatment centres requiring confirmation of clients being free of all prescribed drugs or tablets, childcare and legal issues or judicial status. *Access Issues:* Client unable to access residential treatment. Lead service to question how it deals with suicidal clients. Raised issue of IDSS having access to NAHB funding for referring specific cases to residential treatment. *Need for Street Work:* Scheduling street work into service plans and daily routines is a required priority area of development by the IDSS. Recommended that service begins by dedicating 20 hours per week to street work or three hours per day. Street service will give the service a profile. *Premature Client Deaths:* The staff at the IDSS report at least eight people who were registered clients of the service or regular contacts have died prematurely within the last two years. *Methadone Side Effects:* The harmful side	The IDSS has served approximately 500 clients since 1996. Many clients view the service as their permanent first port of call within the continuum of drugs services and in relation to their general welfare. *Life Saver:* Some clients suggest that IDSS has been a life-saver for them. The daily work of the service is well co-ordinated and responsive to clients needs. The staff have a proven track record with clients and agencies. The IDSS has developed a high profile with other agencies and a wide network of support contacts within statutory, voluntary and community providers.

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	and families can return at any time for support, emergency care, and practical help. The management committee has an agreed vision and priorities which include; client support, family support, advocacy, crisis care and bereavement. The IDSS aimed to offer access, advocacy and a non-therapeutic approach to support. Location in an area with a large drug culture was seen as important as families needed	*How long in operation:* 1988-2001 Ongoing.	Soilse for assessment purposes. The main work of the service can be presented as follows: • Client Support – Key worker and co-ordinator • Advocacy on behalf of the client with other agencies – key worker and co-ordinator • Family Support – co-ordinator • Crisis care and support (including homelessness) – co-ordinator • Bereavement support and practical help – co-ordinator • Client assessment – key worker and co-ordinator • Access to residential care and referral to agencies – key worker and co-ordinator. A file is kept for each client who visits the service. Hard copy files	*Service rating:* The IDSS service receives a generally excellent commendation from clients but the clients are less impressed with the premises. The premises of the IDSS are lowering an otherwise generally excellent service satisfaction rating. *Empowerment:* All fourteen clients stated they felt empowered by IDSS in their recovery process. Just over half the clients felt empowered generally by drugs services. 18 respondents felt the IDSS was user friendly. The ICON Drugs Support Services compares well with other services in the experiences and perceptions of the clients who took part in the evaluation. *Management Evaluation Of IDSS:* Morning session and survey questionnaire similar to	effects of maintenance programmes, particularly in relation to prescription drugs which are necessary to sustain methadone maintenance are being raised as issues by clients of the service. *Lack of Client/Family Representation:* Clients and families do not have any meaningful representation on the management committee of the IDSS. This may be a participatory structural weakness from both community and quality services perspectives. Meaningful representation would involve family members and clients. *Inter-Agency Issues:* Management reservations mainly in relation to issues of inter-agency systems and co-operation about how best to meet the needs of clients in the past. *Need for Greater Publicity:* Communicating the achievements of the service and the expertise of the staff as a team to the wider community is critical to the success of the service. Team building and gaining a shared knowledge of the achievements of the service should be a priority development of the co-ordinator, staff and Management Committee. User participation and representation is vital. *Management Issues:* Comments from individual members of the management	

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	a place to go. *How define rehab* The IDSS service recognizes that support for addicts is a long-term commitment that needs to respond to the changing needs of clients at different stages of the life cycle.		exist for 33 clients. All the work of the service is Outreach Work as defined by the Northern Area Health Board as 'a first point of contact'. The outreach work also involves a significant amount of dealing with homelessness and out of office visits and street-work. There is a considerable amount of support provided to clients receiving prescribed methadone; there is support for active drug users and ongoing support for post rehabilitation clients who are remaining drug free. Direct inter-agency work makes up 5% of the work. Most of this work is the inter-agency management of care pathways with individual clients on an informal basis. Family support work takes up about 20% of the support outputs.	one completed by clients. *Prioritizing Services* It puts client support, advocacy, care, and family support, at the core of the mission of the ICON Drug Support Service. Recognizes that IDSS is not primarily a referral service but rather a first port of call for support for families and clients in accessing services and moving between services and ongoing support and crisis care. This shows a convergence between the perspectives of clients and management on the role and responsibilities of the IDSS that is reflected in the job description of the Key-Worker and co-ordinator. There has been an efficient delivery of the service since its inception and the integration of new staff and their workloads plus the development of a team spirit that clearly exists	committee, 'There are no clear roles for individual members of the management committee; there is a vague collective role'. *Developmental Issues:* • Co-ordination – additional staff to relieve pressure on co-ordinator. • Staff development – training in addiction, outreach and administration, support groups e.g. parents, peers, bereavement. • Management functions and development. • Work-plans. • Premises. • Client records. • Local credibility. • Statutory credibility. • Research. • Conferences • Service expansion. *Need for Staff Support:* Support for the co-ordinator and staff development and staff-management relations and functions plus work-plans and premises are all the top of the list for development. *Need for Team-Building:* Team building for the management committee as a whole is recommended as a priority. An inter-agency and inter-sectoral approach in the management of a community led service is the recommended model, similar to the	

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			The staff feel it is important for families to get an understanding of addiction and support for themselves. They regard family support or lack of it as very influential after residential treatment. Peers bring a lot of experience and knowledge into this work with them. They bring their own experience of active addiction and the challenges and obstacles they faced trying to overcome addiction. Peers feel a sense of identification from and with the client, which helps build trust. The staff of the IDSS are peer support workers in a family and community setting. Without such a setting the nature of their work would be different. *Care Planning:* The staff describe the service as an information, referral and support service. They believe care planning is not something which can	among the staff. The IDSS has demonstrated over time a consistent demand by clients based mainly on word of mouth and peer recommendations based on client's past experience of the service. *Agencies Evaluation:* All of the agencies recognized the IDSS as an equal partner in the continuum of specialist services. When referral to the IDSS was appropriate all agencies did so and seemed happy to be able to do so regarding the service as of benefit to clients. *Joint care of clients with the IDSS:* The co-management of care for clients, co-operation between agencies and across the statutory, voluntary and community sectors, and a move away from agencies making unilateral decisions about clients seems to be	models created by the Integrated Services Process. *Conclusion:* The main issues requiring a response include; advocacy, maintenance programmes which combine drugs with methadone, support for clients through the stages of their recovery, and re-integrating drug users with families, community and maintaining a home. *Poor Administration Capacity:* The service has an under-developed administrative capacity. This has impacted negatively on maintaining a functioning office and the strategic development of the service particularly in relation to; access to residential treatment, co-caring for clients with other agencies, homelessness, family support, bereavement, and crisis care. The IDSS requires administrative support for strategic development. *Service Role Confusion:* Other agencies respect the service and the staff and acknowledge that 'what it does it does well' but there is confusion at agency level and to some extent within the Management committee about what it actually does. The management committee has received no training or development with regard to its identifying responsibilities.	

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			be rushed through, it takes time and commitment. The nature of the service would be changed if they were to take the care planning approach. They do not have the staff or resources. They refer clients to Soilse for that level of support. They have referred sixty clients to the service. All progress made by clients at Soilse is fed back to the IDSS. The staff of the IDSS provide a service which is driven by providing immediate responses to the needs of clients as they arise. One of the principles of the IDSS is that clients have to be self-motivated, that it is premature to look for clients. The service is currently working to create a bereavement group to help people cope together.	becoming the general trend within an overall framework of service integration or inter-agency approaches. Most of the agencies felt that IDSS was very approachable when clients needed assistance. *Agencies rating of IDSS:* The other agencies in the services continuum gave the IDSS a very high rating. Agencies stressed that the IDSS staff need support and dedicated training to keep abreast of developments. Nonetheless overall view was very positive and the IDSS has clearly continued to develop its integration into the agency networks since the previous evaluation. Investment in publicity and profile development of the IDSS would be helpful to both agencies and clients. *Management Committee:*		

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			There may be a lessening need for the IDSS as a trouble-shooter for clients within the service continuum and an increased role in relation to ongoing support, care and developing pathways of treatment with other agencies.	Management committee includes professional volunteers, community groups and local residents, statutory agencies and staff but no clients.		

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Story of a Success: Irish Prisons Connect Project 1998 – 2000. Phases 1–3 *Author:* Paula Lawlor and Emma McDonald, National Training and Development Institute. *Date:* July 2001.	*Background:* Began as collaborative undertaking by Dept of Justice, Equality and Law Reform and National Training and Development Institute of Rehab Group. *Aims:* To establish an individually-tailored approach to rehab through vocational preparation in Mountjoy Prison, the Dochas Centre and the Training Unit, which is both multi-modal and multi-agency. Project is being expanded to all prisons in Ireland during 2000 – 2006. *Specific Objectives:* • Enabling and encouraging offenders in prison to make well-informed choices and to use their time in custody beneficially. • Evaluating existing work and training service provision in	*Target Group:* Offenders, male and female in Mountjoy Prison, the Dochas Centre and Training Unit. *Cost of Programme.* Funded by EU INTEGRA Employment initiative from 1998 to 2000. *How Long in Operation:* 1998 – 2000.	*Approach:* Multi-modal and multi-agency, and is individually focused in seeking to overcome the needs of specific population of offenders. Organized around 4 phases, each of which had a research and an action component. This section reviews phases 1 – 3. *Phases 1 – 2:* Examined perceptions of prisoners, staff and management regarding needs of prisoners to identify strengths and weaknesses of system. Suggestions for improvements to system also elicited to establish how prisoners' needs could be better met. Phase 2 examined more specific needs of: • female prisoners, long- term prisoners, and evaluation of training provision	*Findings (Phase I):* • No area of need totally neglected nor fully met. • Prisoners and staff differed in opinions and perceptions of situation. • Most services could not deal with the demand for them. • Prisoners involved in developmental activities were not using them to full advantage or towards clear goals. *Findings (Phase 2 Women Prisoners):* • Need for greater choice in developmental activities. • More assistance in planning/decisio n-making. • Need for employment or training	*Restricted Places:* Number of places in developmental activities available to prisoners in Mountjoy, the Dochas Centre and Training Unit is limited. *Unfocused Developmental Activities:* Occupants did not appear to be using the developmental activities to their full advantage, did not have access to preferred activities, and did not undertake activities for long term gain. It is difficult for prisoners to achieve anything through activities without clear goals to work towards. Reports indicate that developments were more focused on personal development and decision making regarding living crime free rather than on choosing a particular career. *Limitations of Project to Date:* The objective of the Options Programme to	

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	prisons to ascertain whether it meets the needs of the various client groups (male, female, long sentences, staff training needs etc). • To establish clear and effective linkages between in-prison and out of prison services (e.g., employers, training agencies, educational establishments, voluntary agencies, etc).		in Training Unit. *Action Plan (Phase 1):* Develop and introduce a Needs Assessment System, Individual Programme Planning System (IPP), Pre-Vocational Training Programme, and bridging programme from Drug Treatment Programme in Medical Unit to different regime in Training Unit. *Phase 3:* Focused on links with community outside the prison. Surveyed attitudes of employers, training agencies, educational establishments and community services on integration of ex-offenders into their systems. Explored offenders' needs reintegrating into community after release.	information. • Gender-specific training provision linked to job opportunities in the community. *Findings (Phase2 Long Term Prisoners):* • Loss of contact most difficult issue for long-term prisoners. • Lack of activity. • Seeing others coming in and out of the system. • Keen to establish positions of responsibility and provide informal support to other prisoners. Connect view this as a resource to be tapped by prison for benefit to all involved. *Findings (Phase 2*	assist participants in making a definite vocational choice appears from this evaluation not to have been achieved for the majority of participants. *Phase 1 Recommendations:* • Expand, develop and better co-ordinate existing services. • Improve circulation of information within prison. • Better assessment of prisoners' needs. • More preparation for prisoners before they commence developmental activities. *Phase 2 Recommendations (Women Prisoners):* • Needs Assessment System, • Individual Programme Planning (IPP), • Pre-vocational training, • Job-specific training. *Phase 2 Recommendations (Training Unit):*	

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				Training Unit): • Satisfaction with training received. • Good relationships between trainees and staff. *Findings (Phase 3):* • Half of employers surveyed said they would consider employing an ex-offender. • Figure rose to 63% if support would be provided for employers. • Other employers showed widespread prejudice towards ex-offenders who are seeking employment in the community (i.e. certain offenses make a person ‘unemployable’)	• Direct referral system for instructors to bring concerns to appropriate services. • Personal and educational supports to ensure trainee programme completion. • Revise induction to fully brief trainees. • Revise specifications for each training programme in light of individual trainee capabilities (i.e. course duration, training plans, certification procedures, timekeeping/attendance problem procedures, record keeping, feedback procedures).	

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				. • Most training agencies, educational establishments and community services willing to integrate ex-offenders. However, indicated some offenses which would preclude integration, in case other service users or staff put at risk. • Referrals on an individual basis seen as most effective way of facilitating integration and working to change community attitudes towards ex-offenders.		
Options Pre-Vocational Training Programme Evaluation. Phase 4.	*Aims:* • To prepare participants for work/training/education; • To enable	*No. of Clients:* 501 applicants from Mountjoy; 45 applicants from Dochas Centre to date. Total of 106 participants commenced	*Background:* Options pre-vocational training programme designed in response to needs elicited by Phase 1 Research.	*Participation to Date:* • 7 Options programmes completed in Mountjoy Male	*Non-Completion:* • 16% dropped out of own accord. • 16% asked to leave due to non-compliance with group rules.	*Participants' Perceptions on Whether They Changed:* • 92% reported they had changed as a result.

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Story of a Success: Irish Prisons Connect Project 1998 – 2000. *Author:* Paula Lawlor and Emma McDonald, National Training and Development Institute. *Date:* July 2001.	participants to make informed choices with regard to which development activity to take part in, in prison, if any; • To encourage participants to take responsibility for their own development.	and 86 completed programme (73 Mountjoy, 13 Dochas Centre, which represents an 82% completion rate. *Target Group:* • All prisoners eligible to attend except the segregated. • Must be motivated to become involved in work/training/education. • Not currently abusing drugs to the extent that cannot take part in programme activities. • Preferably unclear as to his/her vocational direction.	*Programme:* • Lasts between 12 and 14 weeks. • Run five days per week, morning and afternoon sessions. *Progress:* Participants who attend the Options Programme commence work on the IPP system some weeks before the Programme ends. All Options Programme Participants progress to IPP system and from there take a variety of routes before release. *Selection:* • Based on four-stage process designed to ensure that applicants are motivated. • Advertised in flyers (in cell) and on walls (main prison). • Provide literacy assistance with completing application forms.	Prison and 3 in Dochas Centre. • High level of applications (501 for Mountjoy and 45 in Dochas Centre to date). • 106 participants commenced and 86 completed the programme (i.e. 82% completion rate).	*Suggestions for Additions:* • Money management. • Career guidance. • Maths. • Anger management. • More information on STD's. • Information on drug abuse. • Need for refresher course or follow-on course from Options (because some people are lost when the programme finishes, and there is a need to revise). • Parenting and parenting days. • Discussion and debates. • A video on Friday afternoon to help the group unwind and relax. • Add drug counselling or counselling in general to the programme (because drugs are a huge problem for most of the prisoners). • 41% said no other topic they would add.	• Most felt course helped them to develop on a personal level, particular increases in confidence and communication skills, increased ability to express their views. • 44% felt more confident/more hope. • 28% have better communication skills. • 21% less aggressive/can handle their temper better. • 18% more easygoing/calmer/more tolerant. • 15% look at life differently/attitude is different. • 15% not taking drugs now/have changed mind about drugs/want to put drugs behind them. • 10% head straight/more clear thinking/focused. • Most felt it helped them to think differently about themselves and their lives, gave a sense of

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			• All applicants interviewed by Project Coordinator/Assistant and the Facilitator/IPP Mentor. *Course Format:* Course is organized around group work sessions and individual consultations with relevant parties. *Nine Programme Modules:* • Vocational Exploration • Job Seeking • Confidence Building • Assertiveness Training • Stress Management • Problem Solving and Decision Making • Time and Leisure Management • Healthy Lifestyles. Also involves: • Participant		*Other Suggestions:* • Running the programme after tea. • Having one-to-one sessions to help revise the material covered. • Attracting more people to the programme through better flyers or brochures. • Providing for larger numbers either by expanding the group size or running two programmes at a time, while others wanted a second stage to the programme. • Getting concessions for doing the programme, and leaving it for people coming to the end of their sentences to help them get out the door. • Adding a computer course. • Having more talking and less writing.	the future and new life skills beyond prison. • Felt rehabilitated, i.e. more prepared for release. • Felt able to tackle issues such as drug addiction and face up to problems on release. • Viewed vocational/training elements as secondary to more personal elements of the programme. • Had more information about their options and knowledge of what is out there for them. • More aware of their skills and what they have to offer. *Course Expectations:* • For most, course exceeded expectations, although some found it difficult or didn't see enough changes. *Selection Process:*

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				information seeking • Presentations from invited speakers on career or vocational areas, supports after release, and • Personal development through group discussion (e.g., development of social skills). *Progression Routes From Options:* • Released • Training/Education in Mountjoy. • Training/Education in Training Unit. • Drug Therapy Programme in Mountjoy. • Transferred to a Prison other than the Training Unit. Most participants either remain in Mountjoy or are released following participation in the programme.		• Majority (74%) no suggestions for improvement. • 39% said present selection process is best or fairest way to do it. • Some suggested giving it to people when they first come into prison. *Most Useful Parts:* • 30% reported confidence building. • 18% reported whole programme of benefit. • 13% reported Assertiveness module. • 13% reported Communication Skills module. • Others reported knowledge of self and opportunities. • 46% liked everything on the programme, or reported that everything was useful or brilliant. *Views on Facilitation:* • 56% felt that facilitator(s) ran

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						program excellently and 46% said they ran it very well. • 95% reported that their opinions were listened to on the programme. 80% said they understood what was being discussed on the programme. • 39% reported that facilitator re-explained things well on request. *Group Size:* • 51% reported that a group size of 12 – 14 would be ideal. *Programme Length:* • 62% supported between 12 and 14 weeks. • 31% said from 6 weeks to a year, because time was needed to cover all the modules comfortably; to allow the group to bond or settle in, to allow for time to discuss issues 'because the time flies'.

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						Outcomes on Release: • 55% unknown. • 32% gained employment. *Conclusion:* Although the programme was initially designed to prepare participants for work and training this seems to be viewed as secondary to the more personal elements of the programme by participants in particular. An underlying philosophy of the CONNECT project is that putting effort and energy into assisting people who may feel forgotten sends a clear message to them regarding their personal value and the fact that their value is not determined by what they have done. The aims and objectives of the Options Programme may need to be revised to reflect the actual benefits to

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						participants in the personal domain in the context of an overall vocational preparational strategy. The Options Programme appears to have achieved its aims of encouraging participants to take an active role in their own development (e.g., changed attitudes, more social and personal skills including increased confidence) and future career direction.
Vocational Training Programmes Evaluation. Phase 4. Story of a Success: Irish Prisons Connect Project 1998 – 2000. *Author:* Paula Lawlor and Emma McDonald,	*Aims:* Review of existing training programmes and workshop activities in Mountjoy Prison, Dochas Centre and Training Unit to ascertain whether training/work available in prisons meeting needs of prisoners taking part, and whether meeting highest standards.	*No. of Clients:* 274 individuals commenced training on programmes either set up or modified by the CONNECT Project between Jan-99 and Dec-00.	*Programme:* These systems provide additional support for the trainee to assist them in achieving their goals, both technical training goals and work related social or personal goals. *Certified Training Programmes Introduced: Mountjoy:* • Industrial Cleaning • Computers • Bakery	*Certification:* Of the 274 individuals who commenced training, 104 achieved certification. *Mountjoy Certification Rates:* • 80% for Industrial Cleaning, and 80% for ECDL. *Training Unit Certifications:* Levels of	*Suggestions for Improvements to Training:* • Majority of trainees suggested opportunities for more advanced training in their area. • Training programmes to run more smoothly. • A quieter environment. • Stricter rules for behaviour in the workshops. *Note:* These suggestions were encouraging as they show that trainees are	*Participant Views of Training Programme:* • A large majority - 92% thought that their training would be of use to them in the future. *Views of Training Staff:* • All training staff interviewed said that their training programme was of benefit to participants. • 67% said this is because they can get work on release if

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National Training and Development Institute. *Date:* July 2001.			• Welding *Dochas Centre:* • Industrial Cleaning • Sewing • Hairdressing *Training Unit:* • Welding • Computers • Gen. Engineering • Electronics	certification much lower due to course interruptions (being sent back to Mountjoy for drug use or breaches of discipline): • 27% Electronics course. • 29% Computer course. • 28% Welding course.	taking their programmes seriously and are interested in furthering their skills. *Record Keeping:* • 50% of training staff surveyed found the training record keeping system cumbersome, long-winded and time consuming. *Promoting the Rehabilitative Culture:* Implementation of the project required an enormous culture shift within the prisons. Actions required that the prisoner take ownership and primary responsibility for his/her own rehabilitation. It also required that he/she be placed centre-stage in the training process. The implications of this for custody/care dilemma have been considerable. Participants have responded to this in a positive way although it	they are interested. • Benefits to trainees include discipline, a work ethic, and a marketable skill. • 67% happy with level of support received from NTDI Connect Project Staff. • 67% said the introduction of the CONNECT Project had made a positive difference in the prison. *Mainstreaming:* • The mainstreaming of the CONNECT Project has been achieved through its inclusion in the National Development Plan. • CONNECT will continue in Mountjoy male prison, Dochas Centre and Training Unit, and expanded to five other prisons nationwide during 2001. Further plans to expand project to all prisons nation-wide by 2006.

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					represented a major shift in their thought processes, through the IPP system (Individual Programme Planning). They have shown a clear commitment to working toward their future goals in a structured and systematic way. *Prisoner as Client/Service-User:* The image of the prisoner as client and service-user in the Work and Training area was a departure from current practice. Extensive meetings were held to put this point across in the least threatening way possible. Periodic briefing sessions were pivotal in acceptance of this new way of thinking and acting towards prisoners. Any culture change takes time and happens gradually. *Limitations of the Project to Date:* • Some staff dissatisfied with amount of information they receive about the	*Main Innovative Aspects:* • Project itself is a new departure in combating crime by addressing social inclusion through employment for ex-offender. • Collaboration of Dept of Justice, Equality and Law Reform with an external expert consultant in the area of rehabilitation is an innovation which was highly successful during the CONNECT project. • CONNECT differs from other rehab systems by looking at both intrinsic and extrinsic factors correlated with criminal behaviour which act as obstacles for the person in breaking the cycle of offending. Lack of secure employment is a dominant obstacle which faces most, however research shows that ex-

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					CONNECT Project and its progress. Some commented on need for more meetings to ensure that all are kept up to date. • Phase I objective to set up a bridging programme from those transferring from the Drug Treatment Programme in Mountjoy to the Training Unit was discontinued after the second programme as the Facilitator requested to return to his previous job. No advances were made to reestablish the programme. Therefore the needs of this specific group identified by the research are not being met in the manner envisaged. • An action planning process commenced in the Training Unit was discontinued due to difficulties in having recommendations implemented.	offenders who secure employment on release are 30% - 34% less likely to re-offend. Overcoming barriers to employment, along with other barriers which prevent offender/ex-offender from moving forward, is the way CONNECT has addressed this issue. • The conduct of action research was a new departure within Irish Prisons Service. • Offers a holistic approach with multidisciplinary methodology to deal with prisoner's needs to ensure that every facet of prisoner's needs are addressed so that progression in one area would not be hampered by difficulties in another area. • CONNECT has reinforced the concept of structured multi-disciplinary working

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					• CONNECT project staff have requested additional training in a variety of different areas for example, in the area of basic counselling skills. • The implementation of the vocational training programmes in Mountjoy and the Dochas Centre was substantially delayed. Therefore the evaluation is limited in the training outcomes it can report. These delays were caused by many factors including the necessity to recruit and train staff along with the need to properly equip training areas.	within prisons, by means of the IPP system, linkages with the community and transnational work regarding the development of best practice. The IPP system allows all prison staff and outside agencies working with an individual prisoner to work in a co-ordinated way to address the individual's needs and help them achieve their goals. • The initiatives of CONNECT were introduced on a phased or layered basis, with consultation and opportunities for feedback available to both staff and prisoners at every stage in the process. This inclusive strategy promotes acceptance of change within the system and encourages both staff

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						and prisoners to participate in new initiatives when given input into its development. • The CONNECT Project recruited and trained Prison Officers in each prison location to run new initiatives that were introduced. This allows the skills and talents of Prison Officers to be tapped and used as a resource to aid the rehabilitation of offenders as well as ensuring safe custody. • The approach of CONNECT was proactive rather than reactive. On a system level, it actively sought to uncover gaps in the existing and developing system and aimed to fill them rather than wait until intervention becomes an urgent requirement. • Project actions are needs driven and

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						aimed at reintegration into the community and more specifically into the workforce. They place the prisoner at the centre of the process and attempt to encourage him/her in a support way. This client-centred approach is innovative in that it enables identification of potential problem areas for each individual before they reach crisis point and will ensure that interventions are designed to tackle any potential roadblocks to development.
From Residential Drug Treatment to Employment: An Interim Report (1999). Author Marie Lawless and Gemma	To develop, evaluate and disseminate a model of good practice in relapse prevention using a locally based holistic programme which facilitates the integration of former drug users into mainstream training/work placement and employment	*No. of clients on programme:* 22 (target was 25). *Target groups:* There are three target groups: 1. Former drug users (over 18 years of age, who have been drug free for at least two months). 2. Training Providers.	*INTEGRA Employment Initiative:* Programme responded to a gap in drugs service provision highlighting the difficulties former drug users experience accessing employment, education and training opportunities once they have achieved a drug free status.	*Programme effectiveness measured by:* • Attracting long-term unemployed (86%). • Attracting many clients under 25 (36%). • Attracting individuals with low educational	*First Year (Implementation Phase) :* • Securing suitable staff and setting up premises for Day Programme proved difficult and time consuming. • Programme structure had to be adapted to meet more complex client needs than had	• Securing a bank of employers to participate in the programme. • Attracting its target population. • Maintaining a 73% completion rate in its first operational year. • Securing educational, training, and/or employment

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Cox (1999) *Name of Programme:* Merchants Quay Project residential programmes (1999)	opportunities. To engage employers and training providers in a process of education, which will assist them in coping with issues surrounding drug use and ease the insertion of former drug users into the labour market. *Client Group Aims:* Former Drug Users • To facilitate the integration/re-integration of former drug users into the community. • To enable former drug users to acquire training/re-training opportunities and employment opportunities. *The objectives are broken down into three categories:* • Integration. • Social Stability. • Training and Employment.	3.Employers. *How long in operation:* Jan-98 – Mar 00.	The model is participant centred, flexible, inclusive, and reflexive. *First six weeks primary focus is:* • Transition between residential drug treatment and re-integration programme. • Letting go of intensive supports offered in residential treatment. • Empowering participants to take on increasing responsibility. • Encouraging participants to develop positive external support networks. • A day programme should operate during this phase offering sessions in personal development, relapse prevention, care planning, and	attainment, and in need of training (69%). • Attracting many female clients (32%). • Maintaining 73% completion rate in first operational year. • Securing educational, training/employment opportunities for 88% of clients who completed programme. • Securing work placements for 75% of clients who completed programme. • Securing full-time employment for 63% of clients who completed programme.	been anticipated. • Immense difficulties in accessing 'drug-free' clients. Hence difficulties in recruiting clients. • Some clients who have high levels of educational attainment (e.g. leaving certificate, first year university) expressed frustration with Day Programme training content (i.e. material very basic and not challenging). This suggests that Integra Programme may not be the most appropriate intervention for individuals who have high levels of educational attainment. • For less educated (some female/mothers) clients, disappointment with the workshops in Day Programme (not relevant to their situation because did	opportunities for 88% of its clients. • Securing work placements for 75% of clients who completed the Programme. • Securing full-time employment for 63% of those who completed a placement. An evaluation at the end of their first operational year indicates that the programme successfully accessed its target client group (long-term unemployed, under 25 years of age, with a low level of educational achievement and a high proportion of females). Drug Awareness Training was delivered to 15 trainers from voluntary and statutory organizations. The evaluation reported a 73% completion rate, with 88% of those who completed the

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	Training Providers • To encourage voluntary/statutory training agencies to attend a specific 'Training for Trainers' programme highlighting the personal, social and environmental context of drug use. *Employers* • To motivate employers to provide work experience opportunities and full time placements for our programme participants. • To equip employers to deal supportively with the issues of drug use as they arise in the workplace. *How define rehab:* To promote the inclusion of former drug users into mainstream society, in particular employment and		weekly self-assessment and computer applications. During second six weeks focus moves to: • Employment and job skills. • Interview techniques. • Work placements. • Accommodation search/options. • Educating and training needs. • Budgeting. • During this phase participants begin to attend the Support and Aftercare Group. The majority of participants attend a work placement two/three days per week. They participate in workshops the other two days. *Key worker involvement:* Key worker assigned to each participant upon		not want to access a work placement, a desire for further education). • *Issue of housing:* some clients did not want to leave the Re-Entry house (client reluctance to leave, through choice or necessity, had not been anticipated by Integra Team). Due to lack of suitable, affordable housing in Dublin, clients were consistently having problems finding accommodation. • Hence, difficulty attracting appropriate clients (reality of Integra programme was quite different to some clients' desires.) Felt elements were inappropriate for them (in particular the workshops). • Found inappropriate matching of a client to a Programme can hinder a client's recovery. Lack of interest, followed by	programme going on to take up educational, training or employment opportunities. Of those who completed the programme, 75% were forwarded to work placements, and of those completing the work placement, 63% went on to full-time employment.

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	training services using a multi-agency (holistic and integrated) approach to groups excluded or at risk of exclusion from the labour market. Merchants Quay believe that a training and education programme comprising a therapeutic element would facilitate social integration.		entry to the programme to ensure continuity and consistency of care. In this model, participants begin a care plan at the start of their second week in collaboration with their Key Worker. Care plans are reviewed and updated individually with assigned key workers in one-to-one sessions. *One-to-one care planning:* Participants prepare Care Plans on a fortnightly basis with their allocated key worker. This care plan is reviewed each fortnight which involves a review of the previous targets, an exploration of achievements and difficulties experienced and the setting of new goals and/or targets. The care plan focuses on the following key areas • Health issues.		loss of motivation, could be a contributing factor in client's relapse. • The clients experienced some of the same frustrations as the staff in terms of programme content. In response, the Integra Team were required to be flexible and adapt to the needs of the clients. • One male client placed on three month gardening work contract, but environment lacked support and interaction needed by client. More supportive and interactive environments recommended for future placements. • Provision of internal training: Found Integra Team would require more specific ongoing training to deal with the diverse range of client issues and circumstances (now provided).	

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			• Emotional well being. • Relationships. • Life skills. • Education/training. • Leisure. • Relapse Prevention. • Motivation. • Support networks. • Exploring options for 'moving on' from the programme. • Particular/personal difficulties. • Goals for the coming fortnight. (1) *Referral:* Clients referred both internally and externally (through Merchants Quay/other drug agencies). (2) *Assessment:* Undergo an assessment procedure (selection and progress dependent on client's abilities and capacities). (3) *Therapeutic Process:* • One-to-one counselling.		• Lack of well-defined parameters regarding clients on placements. Many details of a client's placement were ambiguous (i.e. client's job description, duties, weekly working hours, length of placement). • Employers also reported the lack of support they received from the Integra Programme. • Restricted recruiting employers from small to medium sized organizations, but failed to target larger corporations and public sector employers. Have decided to include semi-state bodies, the larger private sector and multi-national corporations.	

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			• Relapse prevention. • Group therapy. (4) *Support and Guidance* • Advice • Support • Monitoring • Training (provision of a Drugs Awareness Training Programme, and a 'Training for Trainers' course.) *PHASE I - RE-ENTRY* Six week residential programme. Clients encouraged to take control of their situation by developing an individual care plan with staff. Activities are designed to increase confidence, self esteem and establish a degree of routine. • General Life Skills • Relapse Prevention Skills • Social Skills • Establish and maintain contact			

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			with family (home visits are an integral part of this phase). Phase II - Day Programme Six weeks subsequent to completion of re-entry phase. Clients are encouraged to participate in pre-employment training to acquire or develop any additional skills. • Personal Development Skills. • Job Search Skills • Interview Skills. *Access to Education /Training/Employment:* Clients will move on from the Integra programme with an appropriate training or employment strategy, which has been agreed with the key worker. • Access to courses and supported work-placements. • Support for employers.			

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			Case Planning • Designing client individual action plans. • liaising with welfare, accommodation and training agencies on an individual client basis. • Advocating on behalf of individual clients with local employers. • Providing ongoing support to clients. *Management* • Establishing the infrastructure of the project (programme development, recruiting staff, clients, setting up procedures, financial systems, devised individual action plans for clients, liaising with other agencies (employer			

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			agencies, training agencies, business (IBEC and ICTU), various drug treatment services and probation services).			
From Residential Drug Treatment to Employment: Mapping a Route from Exclusion to Integration. *Author:* Niamh Randall, 2000. *Programme:* The Merchants Quay Project.	*Aims:* *Former Drug Users:* Three broad aims of Integration, Social Stability, Training and Employment: • To facilitate the integration/re-integration of former drug users into the community. • To enable former drug users to acquire training/re-training opportunities and employment opportunities *Training Providers:* • To encourage voluntary/statutory training agencies to attend a specific 'Training for Trainers' programme	. *Target Groups:* • Former drug users, two months drug free, over 18 years of age, prior experience of residential drug treatment or group work (ideally). • Training providers. • Employers. *How Long in Operation:* The Integra programme 'From Residential Drug Treatment to Employment' officially concluded on 31-Mar-00 following a 3-month extension.	*Selection Criteria:* • A commitment to remain drug free and an interest in developing further coping strategies. • A desire for structure and stability. • Interested in developing/ updating personal, social and employment skills and/or educational/training skills. • Motivation to access and actively participate in the supports offered. *Programme:* Participant centred, flexible, inclusive and reflective (see previous review, 1999).	*Participant Outcomes:* • 65% of participants completed the programme. • 83% accessed a full-time job upon completion of the programme with 4% accessing a part-time job. • 13% progressed to further education. • Attracted 31% female participants.	*Improvements Suggested (Participants):* • More detailed examination and in-depth discussion of various topics and possibly longer duration of the Drugs Education Course. • Possible visits to drug treatment/rehabilitation services. *Challenges Over Course of Programme:* • The economic boom. • The housing/ accommodation crisis. *Model of Integration /Lessons Learned:* • Former drug users have many skills and talents and form a potential labour reserve that has rarely been tapped into.	*Participant Outcomes:* • 65% of participants completed the programme. • 83% accessed a full-time job upon completion of the programme with 4% accessing a part-time job. • 13% progressed further education. • Attracted 31% female participants. *During Final Operational Year (Participants):* • 94% reported had learnt new skills. • 65% reported had expanded existing skills. • 50% reported improved relations with family. • 39% reported improved relations

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	highlighting the personal, social and environmental context of drug use. • To improve the access to mainstream education/training for former drug users. *Employers:* • To motivate employers to provide work experience opportunities and full time placements for our programme participants. • To equip employers to deal supportively with issues of drug use as they arise in the workplace. *Objectives:* *Integration:* To develop relapse prevention strategies. To increase participants' ability to interact with non-drug users and to form and				• By virtue of their life experience they have developed many abilities and coping mechanisms and following a period of drug treatment are highly motivated. This is of particular relevance in our present economic climate of labour and skills shortages. • Engagement in the programme highlighted a gap in service provision. • To become drug free though an end in itself is only part of the process of integration. • Former drug users often require assistance to renegotiate other aspects of their lives. • Employment and training are stabilizing factors and can facilitate former drug users to remain drug free. • Essential to invest in post treatment settlement and	with friends. • 90% indicated that programme had helped with relapse prevention. • 94% of participants who accessed work experience opportunities completed a work placement. *Views on Training (Participants):* • All reported that the course was 'very good' (93%) or 'good' (7%). • Reported high levels of satisfaction with the teaching techniques employed by Training Team. • Many referred to benefits of the subject matter especially the sessions on theories of addiction, motivational interviewing and methadone. • Upon course completion 62% reported having achieved their goals,

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	maintain relationships. To provide information on housing issues. To increase participants' confidence at group work. To establish social support structures. *Social Stability:* • To secure stable housing. • To obtain and maintain welfare entitlements. • To strengthen family relationships. • To develop and maintain friendships. • To reduce offending behaviour. • To improve participants' self-esteem. • To increase self-awareness. • To develop positive leisure activities. *Training and Employment:* • To increase job skills.				integration initiatives to ensure long term success. • Fact that social exclusion is broader than labour market exclusion is clearly indicated in the model we have developed. • Often those who have engaged in problem drug use have lived on the margins of society and therefore to achieve integration a holistic approach must be taken which explores all aspects of their lives. • The centrality of resettlement and integration needs of participants across drug treatment services are evident regardless of current treatment status. • Programme flexibility is important. The importance of building flexibility into training design and delivery has also been identified to ensure that busy employers	with 38% reporting they had started achieving them. *Employers' Comments:* Outcomes generally very positive: • Participants were energetic, highly motivated and intelligent. • Involvement in the programme had changed their perceptions of former drug users. • One employer preferred to take a client (with a known past and active support) than take a risk on an unknown 'CV'. • One employer felt that due to his involvement in the programme he was able to recognize addiction in another staff member and support him in dealing with his problem. In the past he would not have known how to deal

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	• To provide assertiveness training. • To provide self-development training. • To enhance access to mainstream training. • To assist participants to undertake job placements. • To facilitate participants to undertake further education and training.				and their staff can benefit. • Identified the importance of the specific tailoring of any programme to meet the particular needs of programme participants. • Necessity of ongoing reflection and evaluation of any programme to take into account the changing issues, needs and challenges. • Benefits of drug awareness training for training providers, not only for former drug users, but also for the training agency ad their staff. • Integra programme is now being mainstreamed with the support of the South West Area Health Board. There are some modifications to the programme taking into account learning gained over course of the programme. • Our hope that this	with the issue and would have let the employee go. • Employers felt adequately supported and appreciated being kept well informed. *Conclusion:* Programme was successful on many levels. • Attracting each of the target groups (former drug users, training providers, employers). • Many of the aims and objectives for each target group were achieved.

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					model can offer a template to inform Task Force service development and other mainstream service developments across Dublin City. • The drug problem is one best solved through co-operation and information sharing rather than working in isolation and exclusion. *Perceived Barriers to the Recruitment of Former Drug Users:* • The majority of companies said they would take the best person for the job with the requisite skills and experience. However, a candidate with a 'chequered history' may raise questions. Main issues highlighted: • Potential safety problems if worker relapses, they could become a danger. • Health sector: mentioned need to	

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					keep anyone with a history of addictive behaviour away from company held drugs. • Care sector: concern about allowing vulnerable people to be cared for by someone with a potential problem. Also concern that the stress involved with care work, coupled with the strain of shift work may trigger relapse. • Liability if they knowingly recruited a drug user in recovery who then became a danger to existing staff. • Insurance implications with some jobs particularly in some areas of employment. • Concern about effects on existing staff if a former drug user relapsed. • Concern about potential litigation and the subsequent publicity. • Hotel sector	

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					concerned about continual temptation of alcohol on the premises. *Factors Which May Influence Recruitment:* • Financial inducements make very little difference. • On-going support for former drug user in recovery would be useful but regardless of support offered, would pick 'the best person for the job'. Some considered that if individuals needed support they might not be able for the job. • Companies were less probing if they were desperate to fill vacancies. • Length of time drug free was considered important factor. • Most felt more knowledge of addiction and the rehab process would be helpful when considering recruitment of a	

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					former drug user.	
Evaluation Report on RDI's Drug Rehabilitation Sail Training Pilot 2002. *Author:* McAteer Associates. *Area:* Ringsend area of Dublin.	*Aims:* Pilot programmes to provide participants with an adventure which would challenge them mentally and physically and develop their individuality, skills, abilities and leadership qualities. They would be expected, after sufficient training, to achieve particular tasks without supervision. RDI proposed a phased programme which would cover many aspects of sailing, would commence with a short sailing trip and would finally build up into open sea sailing ventures. Two of the strategic aims of the Strategy are particularly relevant to the work of RDI: • To enable people with drug misuse problems to access treatment and other supports in order to re-integrate into	*No. of Clients:* Six drug rehab organizations provided a total of 95 participants (leaders and clients). Participants came from the following programmes: • Children After School Project (Caspr); • North Inner City Community Group (Niccg); • Bawnogue Youth Support Group; • Coolmine Therapeutic Community; • Ringsend District Response to Drugs (RDRD) • The Salvation Army. *Target Group:* Recovering drug addicts.	*Strategy:* Decided to provide 1,2 or 3-day experiences to suit group needs. Each group would consist of up to five clients with one group leader from the providing organisation.	*Achievement of Objectives:* • 8 out of 10 objectives for the programme were achieved. • Objectives 9 and 10 were not achieved as intended because they were too ambitious and underestimated demand from participating organizations. • Participants thoroughly enjoyed their programme aboard the *Rinn Voyage*. • Neither participants nor their organizations had any clear expectations in terms of personal development that might result	*Greater Client Demand Than Expected:* • RDI staff were surprised by the extent of the response to their pilot programme offering. They found themselves having to cater for client numbers by providing a greater number of introductory sailing trips and cutting out completely the proposed longer sea voyages. *Need for More Professional Marketing:* • In many ways RDI has undersold the benefits which it can bring to drugs rehab and needs to adopt a more professional approach to its marketing. • More thorough market research should be undertaken to ascertain the true size of the potential market and to better enable	*Outcomes for Individuals:* • Individual participants found the experience to be both fun and with the potential for skills building. The majority wanted to repeat the experience. *Leaders Viewpoints:* All of the leaders felt that the programme had helped their clients to: • Build team-working skills • Gain a sense of achievement • Build confidence and self-esteem • Develop a fresh awareness of themselves • Do something different that they might want to do again. In addition, some leaders felt individuals had: • Learned some basic survival skills

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	society; and • To strengthen existing partnerships in and with communities and build new partnerships to tackle the problem of drug misuse. *Specific Objectives:* *1.* Provision of a programme through the medium of sail. *2.* An opportunity to develop individuality, skills, abilities and leadership qualities. *3.* An opportunity to build confidence. *4.* Opportunity to encourage personal motivation. *5.* Provision of a catalyst to individual and team development. *6.* Facilitating an adventure. *7.* Provision of a programme that is challenging both mentally and physically.			and they were all pleased to note, in a variety of different ways, that objectives 1 to 8 were achieved. • Something new and innovative in the life of a recovering drug addict can in itself be a beneficial experience. • Although objectives 9 and 10 were not delivered, what was possible to do in a one or two day cruise was done and this has proved to be satisfactory to the client groups. A less ambitious programme for an introductory event would seem to be more appropriate.	RDI managers to plan for the future (e.g. publicity leaflets about the *Rinn Voyager* and the programmes that can be offered aboard). *Awareness of Drug Strategy:* • RDI needs to be more aware of the government's new 2001 – 2008 drug strategy. *Leaders Suggested Modifications to the Programme:* • More in-depth work next time around • A longer period for really learning skills • Fishing for days when there is no wind • Music – the use of a radio or CD player • A greater emphasis on working together/teamwork • 2- day programmes too short to get the full experience of sailing. • For interested people a succession of	• Overcome personal fears and challenges • One leader thought the programme had helped to show a new/different lifestyle and leisure activity. *Leaders Comments:* • Excellent programme, really enjoyable. • Both Captain and Mate extremely sensitive and aware of participants' feelings and problems. • Ten out of ten for team and confidence building. • Very worthwhile programme which provided an outlet for our residents which they would not otherwise have experienced. *Outcomes for Organizations:* • Organizations found the programme to be highly beneficial for their clients. • Pleased with the

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	8. Provision of sufficient training, experience and guidance to allow participants to achieve particular tasks without direct supervision. *9.* Incorporating many aspects of sail training specified in proposal. *10.* Provision of an introduction and short sailing trip, progress to overnight expeditions and finally open sea sailing. *How Define Rehab:* RDI considers that it is supporting rehab programmes as its provision is designed to assist participants in coping with aspects of daily life including decision-making, working with others and working under pressure.				programmes over a longer period. • The young people really enjoyed the whole sailing adventure and said they would love to learn more. *Organizations Suggested Modifications:* • Might be advantageous for Coolmine if RDI introduce a competitive element into the programmes to increase motivation of participants. Coolmine operates a 'clan' system. Allow clan leaders to take on greater leadership roles whilst on board. • Coolmine felt initial experience should be 'fun', but there should be further opportunities , i.e. at least a two-stage programme with clear statements of what will be achieved at each stage and with 'problems' being created during stage 2 to be resolved by clients.	teamwork development and fact that the experience complemented their own programmes to the extent that it involved community living, working together and helping each other. • Expressed delight at how quickly their clients came together as a team. • Noted that those clients with skills in leadership and problem solving came to the fore whilst on board. • Expressed their desire to repeat the programmes but wished to integrate them more closely with their own provision. • For many clients, they also expressed the desire for more advanced programmes. • Having experienced the RDI programme, Coolmine were

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					Stage 1 could be 2 days and stage 2 might be 3 days with further progression for consideration. Coolmine leaders received their first sea-going experience at same time as clients and felt they would have benefited from an earlier introduction such as a 'training the trainers' event. *Need for More Structured Approach:* • The pilot programme needs to develop a more structured approach which matches more closely the needs of the providers and which offers progression for suitable clients. *Evaluator Recommends:* A more careful planning of a series of on-board events, in consultation with the providing organizations, could ensure that each individual participant reaps the benefits of	convinced of the benefits for their clients. *Conclusions:* • The pilot programme was a great success and very popular with participants and their providing organizations. • RDI is well placed as a community organisation in central Dublin to build on this success.

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					each of these objectives. • A proforma 'reference sheet' should be devised for use by the skipper for presentation to each participant to record his or her achievement on the programme. • A confidential 'feedback report' form should be devised for reporting back to the providing organisation on the performance of their group. • The element of 'fun' must be retained.	
An Interim Evaluation of the SAOL Project *Author* Matt Bowden September 1997 *Name of Programme:* SAOL Project (1997)	To reintegrate the women into mainstream life and enhance their employment potential; To offer opportunities for the most marginalized in the community; To provide opportunities for employment and reintegration;	*No. of clients on programme:* Forty four women expressed an interest and 17 were finally selected. Target group: Participants were recruited from the local Eastern Health Board drug treatment clinic. Women drug users living in Dublin's inner city whose chemical	The SAOL Project is an innovative training, education and development initiative for women drug users who have been participants in methadone maintenance programmes. The Project incorporates community development and adult education methods as its main mode of	This evaluation is based upon data from qualitative interviews with project management, staff and participants. In addition, the report draws upon relevant project documents and records. A total of 30 semi-structured interviews were conducted with	The project objectives are not clear in that the first, third and fourth objective seem to be saying the same thing. There was a danger that without the project setting more specific objectives, that it would deny itself the opportunity to reflect on the project concept and to develop an understanding of each agency's position in relation to the objectives; their	On the whole there has been success in helping the women to remain free of opiates and thus reinforcing the withdrawal of the SAOL participants from chaotic lifestyles associated with heroin use. The availability of methadone maintenance to the participants, backed up with the appropriate social and educational supports, is successful in

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	To provide training and development/job preparation and placement. Note: The emphasis of the project is upon reinforcing stability using methadone and not on participants becoming drug free. *How define rehab:* The opportunity for women drug users to reintegrate into normal society which includes the provision of methadone but also encompasses a form of intense structured education and training modules. The project will give women who have been selected from the SAOL project, the opportunity to explore their own potential through an intense participative style of learning which will involve vocational as well as practical skills training.	dependency has been medically stabilized by means of maintenance on the synthetic opiate, methadone. In addition, the participants must: • Live in acceptable standard accommodation; • Be in receipt of adequate, predictable income; • Use good standard child care (to be defined by committee); • Communicate without undue aggression; • Behave in a socially harmonious manner with others in the clinic/centre; • Be a good team worker. In relation to drug use, the selection criteria was that clients be maintained on prescribed medication from one medical source; not be using	intervention. It is also based in the local community where the programme participants live. SAOL is one of the few gender specific projects in Ireland. Those involved in promoting the project were intent upon it being of a training, development and rehabilitative nature and that the focus would not be on addiction per se. The project provides a two-year programme of rehab and support to 16 women participants. *Project Inputs:* • *Personal Development:* The focus of this module was on communication and linguistic skills and implemented through group exercises. The staff	informants. *Observed Identified Outcomes* *Educational Outcomes:* The educational component of SAOL has been successful in shifting the literacy and English language abilities of participants. Indeed, there have been successes in helping clients to develop from pre-literacy to basic education levels, and indeed from basic education levels to an educational level where the Junior or Leaving Certificate can be undertaken. Two participants are preparing for Leaving Certificate English examination at the time of preparing this report. Much of what the project has been	implications for policy, practice and inter-agency relationships in implementing the project. There was a danger that stringent selection criteria might have been interpreted as 'cherry picking' only the least problematic clients. In particular, the social and economic criteria seem, at face value, to be ruling out the very clientele that the project was aiming to include. *Selection of Project Participants:* In interviews with the evaluator, informants from the various agencies reported that the Project was criticized at the time by the City Clinic, and at subsequent times, for choosing clients that were deemed to be 'chaotic' by Clinic staff. The matter of how participants were selected for the project is to a large extent symptomatic of the early stages of the development	preventing the drift back into opiate use for most of the women involved. The SAOL project has been quite successful in enhancing the determination of the participants to remain drug free. It has assisted them in changing their attitudes to substance use. *The project has been successful in the following key ways*: By improving the educational abilities of the women who participated. The emphasis on social analysis, communications and personal and social skills has created a broader critical awareness amongst the participants in relation to the social, economic, political and cultural experience. By providing welfare and childcare supports the project has enhanced the stability of the participants and has maintained their capacity

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		other medication. The element of ‘stability’ would be monitored by urinalysis and would therefore require that the project have a sound working relationship with the City Clinic. *Cost of programme:* SAOL offers a two year programme so that its actual costs over that period are IR£430,000 (i.e. IR£215,000 total annual cost). *How long in operation:* October 1995 to March 1997	used this session as a way of identifying group issues and were then in a position to sensitize themselves to personal and group development processes. • Aromatherapy, Relaxation and Stress Management (v. popular) • Art (Initially unpopular but enjoyed in practice) • Literacy, Numeracy and Creative Writing (This was the cornerstone of the SAOL input. Moreover it is in these modules that the outcomes are more quantifiable) • *Group Work:* The entire development process for the women was conducted as a group. The group became a supportive	about is redefining education and involving the participants in learning processes which are personal, social, cultural and political. The shift in the abilities of participants is happening amidst major adjustments which they are making in their lives. Participant NCVA portfolios involving modules in English, Maths and Communications reveal a very notable qualitative shift in reading, writing, conceptual abilities and confidence over time. In setting out to involve the participants in a process which would lead towards greater employability, as the	of the project. Each agency involved had not had an opportunity to explore the project concept and to find a shared space within a partnership arrangement. It was felt that the build up of unresolved welfare issues for the women was a contributory factor to the destabilization of the participants. This input needs to form a more structured part of the work and perhaps might require a particular staff input dedicated to the provision of advocacy, welfare rights, housing and budgeting support. Indeed it was observed by both staff and members of the management committee that much time was devoted to ‘firefighting’ or advocating on behalf of the women with the agencies. This was also the basis of a criticism leveled at the selection criteria where SAOL selected those more ‘chaotic’. Building in a	to participate. In reinforcing their abstinence from opiates the project has enhanced the stabilization of the women. On the basis of the participants’ subjective definition of their progress, the project has successfully helped them to move further towards employability through increasing their educational capabilities, creating opportunities for personal development and bolstering the women’s understanding of themselves in relation to their communities and society. This report has highlighted the positive which the SAOL project has had in relation to the social dimension. The project could benefit from exploring the possibility of examining the health gains made by participants on a more

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			environment for the participants. • Community Development (focused on reintegrating women back into their own local communities). • *Social Analysis:* Over the period the women have become more aware of their situation and have development a consciousness of themselves as citizens and as members of society. • *Computer Skills:* Computer training workshops were offered by a computer company. Objective was to introduce women to information technology rather than bring about any high level of computer competence. Not	key goal of the ED scheme, the project has, through its educational input, achieved that goal to the extent of improving the educational abilities of the participants overall. Moreover, the project has helped the participants to understand the social and political environment and as such has developed in them a sense of the need for active citizenship. *Stability/Drug Dependence Outcomes* On the basis of urinalysis results, twelve of the fifteen participants were found to have been opiate free (other than methadone) over the period in which they attended SAOL. Two of the remaining three used	more structured welfare component would do away with the danger of 'cherry picking' clients at selection. An initial difficulty for the staff of SAOL in assessing addiction needs of participants was not being party to discussions with City Clinic. Thus, effective joint case management was hampered from the outset. The City Clinic counsellors became involved in providing group counselling to the SAOL project. The staff of the SAOL did not understand, nor did they seek to clarify the meaning of 'group '. The staff of SAOL did not become members of the counselling group, thus they were no in a position to deal effectively with some of the issues leaking from the counselling group. Without knowing what issues were being raised in the counselling	formal and structured basis. *Women's Studies Certificate Programme (UCD):* The project has successfully negotiated a Women's Studies Certificate Programme with WERRC in University College Dublin (UCD). To date 14 participants from the SAOL project have successfully passed all modules, essays and project assignments on the Women's Studies Certificate Programme in UCD, with 11 more project participants this year (2003) expected to graduate. Website: http://www.iol.ie/~saol/

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			all of the participants were introduced to computers. • *Welfare Rights, Budgeting and Money Management:* This was an ongoing issue. The project decided to get involved in the provision of advocacy work in relation to housing, welfare and health issues which was not their primary role. • *Social and Recreational:* The participants were involved in visits to museums, galleries and community projects. This was very popular and allowed the women to discover alternative social and cultural outlets to their previous lifestyles.	heroin (but did not sustain their use), and one had difficulty in stabilizing on methadone in the early stages of her participation. *: Attendance and Communication:* There was a variable attendance and participation in counselling at the City Clinic. The clinic staff reported to the evaluator that there seemed to be a lack of or no encouragement of counselling for some clients by SAOL. Those who maintained counselling contact were reported as having 'done well' or making 'no major change'. SAOL participants were, with the exception of one case, reported to	group the staff of SAOL became compromised. The group counselling service was however withdrawn by the City Clinic after nine weeks. The counsellor recruited to work in-house with SAOL participants reported that she had not enough contact with anyone, and had little contact with the women as a group and felt there was no link with the educational components of the project. Overall, the in-house counsellor felt it was critical that 'addictive behaviours' of the participants needed to be challenged and that it was not possible to separate the addictive process from other aspects of their lives. Contact with, she suggested, addiction counsellors in the City Clinic would have been helpful to her in developing her work.	

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			• *The Crèche Facility:* The need for the facility was established very early on in the project. The crèche has been crucial in enhancing the participation of the clients. The approach used by the crèche staff is to provide some developmental work. Participants tend to work with the crèche leader on issues as they arise, such as challenging behaviour, parenting and discipline. This is a component of the project which staff describe as 'parenting in action.' *Input:* This has been a persistently problematic issue for the project. Addiction	have 'good' behaviour while attending the clinic. *Client Identified Outcomes* *Educational Benefits:* For those participants who had not been able to read prior to commencing with SAOL gaining this ability has opened new doors for them. Overall, participants felt that the inputs which have the largest impact on their lives were the educational ones. This was especially true for those who were pre-literate. Some are buying and reading newspapers and books for the first time. *Health Gains:* There is no way of establishing the extent of health	*Issues Arising:* Relations and communications with the City Clinic have been difficult throughout. It is clear that staff of the clinic thought the SAOL project should have addiction outcomes. The SAOL project management committee never set objectives which were intended to produce an addiction outcome. At the core of this tension is the need to acknowledge that a debate is required as to the goal of interventions with drug users.	

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			counselling is provided to EHB clients at the local addiction centre, the City Clinic. SAOL is an attempt to broaden out from medical treatment and counselling and to provide opportunities to explore learning to engage in training and work. Staff selected for the SAOL project do not have a background in addiction counselling and as such are not qualified to deal with clients within a counselling framework. *Educational Benefits:* The staff gave respect and space to the participants to develop as they saw fit. Opportunities for learning were optimized around everyday experiences as well as through prepared modules. Staff also gave one-to-one support where and	gains made as a result of the group of women being involved in the project. However, the women feel that SAOL has given them strength and reinforced their determination to resist using heroin. The women consider their situation to have improved on the methadone maintenance programme. In addition, their experience in SAOL has given them added confidence. *Social and Personal Development:* It is the broader focus on the individual, their relationships with family and community, and exploration of their citizenship within society which distinguishes SAOL from other initiatives or		

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			when this was required as necessary. *Aftercare:* An aftercare service has been established for women who have completed the programme. This service allows the women to meet once a week (crèche facility).	services. The effect for some of assertiveness and personal development inputs is not to accept the label of 'addict'. As such this may have a negative impact upon services which operate in the addiction context because assertiveness gives the women the power to negotiate the reality which is imposed by the addiction framework. The project has had beneficial implications for the children of participants. Their families felt more assured, more settled. *Vocational Progression:* The Women did give a sense that they had		

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				futures which involved some form of employment, further training and work. However no data is provided on actual progression.		
Soilse-Rutland Partnership Project (1999) Independent evaluation of Phase I of the project. *Author:* O'Donoghue A, O'Donoghue B *Name of programme*: Soilse-Rutland Partnership Project	To provide a quality treatment and rehabilitation programme, based on a continuum of care model of intervention, for drug abusers in the north inner city. The programme involves detox, family mobilization and intervention, treatment, rehabilitation and after-care – combining group therapy, living skills, vocational training and practical socializing – over a one-to-two year period. *Specific Objectives*: • To work with people who wish to pursue a drug-free, non-dependent lifestyle. • To realize the full potential of the	*No. of Clients:* Seventeen people from the north inner city came for assessment and ten engaged with the programme, a further seven people from outside the north inner city also engaged with the programme (these were not funded by NICDTF and are referred to as 'multiplier effect'). *Target Group:* Individuals residing in Dublin's North Inner City and the Northern Area Health Board region that have been affected by addiction to illicit drugs. The project works with individuals aged 18+ of both sexes. First crucial criterion for	The partnership was established as a means of providing a holistic and strategic response to drug use on a continuum of care model utilizing a case management approach (incorporating care plans) and a total drug-free philosophy. The continuum of care recognizes that drug addicts have complex needs, and unless a substantial number of these needs are met, the addict will find it very difficult to become and remain drug free. *Assessment:* Soilse assessment is generally on a one-to-one basis. *The main criteria on which an individual is assessed are:*	*Outcomes for Participants:* • Secure drug-free status • Lifestyle changes • Acquisition of new skills for work/education • Health and social gains • The meeting of agreed, identifiable social needs • Self-motivation, self-confidence and self-esteem. • Family involvement. • Community involvement. • A knowledge and understanding of addiction. *Outcomes for*	The greatest impediments to full and active participation in the programme have been: *Environmental/cultural factors:* in particular homelessness or unsafe living arrangements, family and peer alcohol/drugs abuse and lack of childcare. These areas have been identified as major issues to be addressed: accommodation; childcare; and family/community drugs and alcohol abuse (subject to urgent funding). *Age:* One participant was significantly younger than any of the other participants. It is recognized by the Rutland Centre that the adult orientation of the	Seven of the ten participants have had successful outcomes through engagement with the partnership. The seven additional participants from outside the north inner city have all achieved successful outcomes. The most successful components of the partnership programme were identified by the service provider as: • the experience for participants of living in a safe and nurturing environment, being part of a therapeutic community in Rutland centre • building peer networks and having

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	individual in a holistic fashion. • To provide an abstinence-based response to drug misuse. • To strategically enhance the operations of both organizations by working in partnership. • To establish the partnership as a model of good practice in the field of drug intervention. • To contribute to a drug-free counter-culture in communities, by awareness building on the nature of recovery from addiction. • To promote the recognition within organizations of the primary nature of addiction.	admittance is that the person is drug-free and sober. *Cost of Programme:* Total annual cost is IR£200,000. *How long in operation:* Phase I ran from Dec-97 – Apr-99.	• Commitment to recovery • Motivation to meet ends • Interest in working on their development to achieve ends • Stability. The facilitator will endeavour to ascertain what degree of awareness the individual has, what his/her needs are and whether he/she is therapeutically ready for the residential option and working within a group. The purpose of the interview is to establish the extent of the addiction problem, to explore the feasibility of treatment and to ascertain if the person is ready or capable of undergoing intensive group therapy. The prospective client is asked to bring a family	*Partnership:* • Creation of a continuum of intervention from detox, through treatment to rehabilitation. • Enhancement of the operations of both organizations by working in partnership. • Establish a model of good practice in the field of drug intervention. • Contribution to a drug-free counter-culture in communities. • Promote the recognition of the primary nature of addiction. • Advocate the need for a continuum of intervention, with different agencies working in an	programme sometimes makes it difficult for young people to engage fully with it. *Difficulties in accessing social services* *Difficulties in getting benefits or entitlements* *Health* *Emotional issues* *Cross-addiction/total abstinence from mood-altering substances.* All of the facilitators stated that the first year of operation had involved a significant learning curve. Most of the learning was associated with the environmental /cultural problems faced by participants, the level of preparedness of participants, and the lack of referrals from community /statutory organizations, and the young age of one of the participants. Throughout	their opinions listened to and validated in Soilse. • The existence of a continuum of care approach from detox, through treatment to rehabilitation for participants to engage in, is of particular benefit. The facilitators were in agreement that the Soilse-Rutland Partnership is a model of good practice. The main reasons given for this assessment were: the compatibility of philosophy and ethos; the complementarity of the services; the innovative and efficient use of resources; good communications and lack of bureaucracy; and a high level of professionalism. *Most effective programme components (Rutland Facilitators):* • *Experience* of being in a caring, nurturing environment and

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			member or 'concerned person' to assist in providing relevant information. The person's level of motivation and level of insight are important considerations. *Care Planning:* After assessments, a care plan is drawn up focusing on the needs of the individual. The care plan has to take into account issues such as children (childcare arrangements etc), living arrangements, length of time in detox and the person's involvement in other agencies. *The Soilse Programme:* The programme's emphasis and orientation is a drug-free outcome for all participants. The programme is designed to provide people with skills, both resistance skills and normative	integrated way at every stage along the continuum.	the year, as gaps were identified in the service, strategies were put in place to improve the programme. The partnership is characterized by an openness to learning and a willingness to amend the programme as gaps were identified. *Suggestions and Recommendations, from both facilitators and participants, about how the service could be improved:* • Improvements to the programme. • Resources which need to be put in place to facilitate greater and fuller participation in the programme. Resources that need to be funded and put in place include, a half-way house; childcare; and support worker(s). *Poor Integration of Services (Inter-Agency)*: The partnership maintains that integration of services	living as part of a therapeutic community. The community as "supportive family", provides a safe environment for release of feelings and exploring new identities. • Living in a "drug free community" was cited as invaluable. • The involvement of family (building new relationships with family). *Continuum of care provision:* Many participants are "very vulnerable" on completion of treatment. Soilse provides a back-up and holding mechanism. *Partnership with Rutland:* Giving full attention to working on an individual's addiction. A crucial element in the continuum has been the way participants attending the Soilse programme feed into the

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			skills, to stay off drugs. An adult education philosophy informs the learning practices in Soilse. *Programme Components:* • Creative (art, drama, video, photography, creative writing, dance and movement) • Education (information technology, reading, writing, social analysis and personal development. Talks, workshops and guest speakers on health, nutrition, exercise, sexuality, legal matters, financial matters, social welfare issues). • Recreational (football, aerobics, well-equipped gym, day-trips, residentials, theatre		is the only way forward in combating the drugs situation, however, its experience with other agencies indicates that there is a lot of work still to be done to achieve this. Most agencies are still working in isolation, and do not always respond well to other organizations, even those working in the same field. If there is to be any move towards integration of services, the first step should be a willingness on the part of organizations to co-operate with other agencies. There needs to be far more discussion between agencies, communities and the LDTF about where money is being spent at present, what choices are available for addicts and what the best ways forward might be. *Addiction Training (Agencies/Community Groups)*: Training in addiction for both statutory agencies and	Rutland after-care. *Conclusion:* It is quite clear that the Soilse-Rutland partnership programme has been successful in its first year of operations. Although numbers entering the programme were not great, seven out of ten of the participants who engaged with the programme have achieved, or are achieving, successful outcomes. *Participant Perspectives. Facilitators:* Eleven out of twelve respondents spoke very highly of the facilitators in Rutland. The general perception was that they are very caring and compassionate, without being enabling. *After-care Group:* Ten out of the twelve respondents have actively used, or actively use the after-care group. Most have never missed a

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			visits and outings to exhibitions). • Addiction education and counselling (career guidance and counselling services, group-therapy work is encouraged). *After Care:* Soilse provides after care in the form of an 'open-door' policy with regard to use of the resources by past participants, follow-up career guidance and one-to-one counselling. The interaction between facilitators and participants is central to the programme. Also, some of the staff have been past participants, therefore they are good role models. No one person is assigned to a specific facilitator – Soilse		community groups is also vital. *Continuum of Care Package:* There needs to be greater recognition by policy-makers and organizations of the need for the provision of a continuum of care package, this could then point a way forward towards integration. *Note:* Since there already exists an outline of a strategy towards combating the drugs crisis in deprived communities, in the form of the Lord Mayor's Commission on Drugs Report, it behoves the LDTF and other agencies to commit themselves to implementing the recommendations in that report, specifically those on comprehensive drug treatment and rehabilitation services. *Relapse:* Of the ten people recruited since December 1997, two completed but	session: "I haven't missed a night in a year and a half", "I live for it", "The aftercare is a godsend – the best". *Soilse Programme:* Responses indicate a high level of satisfaction, and great enthusiasm for the Soilse programme. One respondent commented, "It would be good to have Soilses all over the country… there should be an option like this for everyone who comes out of a treatment centre". *Sense of Self:* Eleven of the twelve respondents stated that participation in the Soilse-Rutland Partnership Project had improved their sense of themselves and given them a more positive aspect (e.g., more confidence, less self-loathing, or self-pity). It is clear that participation in the Soilse-Rutland Partnership Project has helped the participants develop self-esteem and

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			encourages participants to link-up with all facilitators – in reality, however, participants may use one facilitator more than another. An option of undertaking modules through the NCVA and City & Guilds is also offered. The emphasis of the programme is *process* rather than *goal* orientated, therefore participants are given the choice whether to undertake NCVA or not. *The Part-time Programme:* Participants engage with the part-time programme before and after treatment in Rutland Centre. Length of time on the part-time programme varies with participant, and ranges between two months and four months. Max 15 people in part-time at any one time.		relapsed very soon after leaving, one was asked to leave; three completed treatment but left without completing the full-time programme, two successfully completed the programme, two are finishing treatment in Rutland centre. *Facilitators Perceptions Environmental/cultural factors:* The greatest impediment to full participation in the programme, "the forces against their recovery are sometimes stronger than forces for". The environmental/cultural factors identified: • *Homelessness/unsafe living arrangements* (two of the participants did not have any place of their own to return to on leaving Rutland: "It was a huge worry for me", "When your using you'd sleep anywhere… but when you come out of Rutland you're very	self-confidence, and most importantly, given them hope. *Development of Motivation:* Ten out of twelve respondents showed good motivation, and many stated clearly what they wanted to achieve. *Development of Interpersonal Skills:* Seven respondents believe that participation has helped improve their relations with their family. Most said that CP days in Rutland were the starting point for these changes. Three participants said they are making friends for the first time, as they tended to isolate themselves when active. For seven respondents the biggest change for them is how they now deal with authority figures (e.g. police/prison wardens). *Greater awareness of addiction:* For all

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			The programme involves three half days per week, and comprises of urine screenings, group work, creative modules and talks. Participants must also attend the pre-entry group in Rutland Centre prior to treatment, and the Rutland after-care programme once treatment is completed. *The Full-time Programme:* After part-time completed satisfactorily, participants move on to the full-time programme. This lasts four months and takes max 12 people. Five days a week, attendance obligatory. *Criteria used to assess participants' progress on the programme are:* • Total abstinence from drugs and		vulnerable…it's really important to have a place to go…These things are huge issues for a lot of people. One could not return to his partner because she is still using. • Family alcohol/drugs abuse. • Domestic violence (physical/sexual/emoti onal abuse). • Lack of childcare. • Children in care. • Community full of alcohol/drugs (A problem for six of the respondents, having to be around people drinking, taking drugs or on methadone maintenance, after they left Rutland. For many, their only solution was to avoid old friends and give up socializing, or had no alternative but to live with people who are still 'active'). • *Financial problems* (cited by five of the respondents, difficulties claiming	respondents their awareness of addiction impacts directly on how they now live their lives. Four respondents spoke of total abstinence philosophy of the project, and how this had helped them understand and cope with their addiction. *Attitudes to Methadone:* Some said their experiences on methadone convinced them that it could not be a solution to addiction. Two thought it was OK as a short-term measure. Two reported that they had "major problems" being around people on methadone. *Conclusions:* Undeniable that the Soilse-Rutland Partnership Project is perceived very positively by eleven out of twelve participants interviewed, only one had an unfavourable report (possibly related to his youth). It seems that the Rutland programme may

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			alcohol • Engagement with the programme • Levels of commitment • Satisfaction with the programme • Self-reflection and self-sufficiency • Respect for others • Meeting social needs • Understanding of addiction and recovery • Engagement with Rutland after-care Facilitators meet regularly to discuss participants' progress, and if the above criteria are not being met, an individual is given 'time-out' followed by discussion. Participants are given the option to return to the programme, or find an alternative occupation. *Relapse:* If a person relapses on the		benefits) • Peer pressure/sabotage. • Crime. • Lack of quality of life. • Lack of education. • Lack of skills. • *Emotional issues:* Four of the respondents had a very hard time dealing with resurfacing emotions they had kept down by using drugs,. For two participants, the hardest feeling of all was dealing with grief: they had both lost family members through drugs and were only now beginning to mourn them. Fear was also mentioned (e.g. found it hard to talk to people). Recognition by all facilitators of vast differences between north inner city people and people from much more structured, intact communities and families. Most north inner city	not be ideal for younger recovering addicts. All respondents found it challenging but useful and would recommend it to others. Eleven out of twelve said they were being, or had been prepared for independent living and work, and ten out of twelve showed high levels of motivation. *Participant Outcomes:* • 3 in jobs. • 2 doing other courses. • 1 entering CE scheme. • 2 applied for Access Course in TCD. • 11 reported increased self-awareness, self-esteem or self-confidence since starting the programme. *Conclusion:* The Soilse-Rutland Partnership programme is a model of good practice; the continuum of care approach was an effective model of intervention.

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			programme, always given a second chance. If the person is on the full-time programme, they may be asked to return to part-time. The premise is that 'relapse is part of recovery.' Relapse prevention work focuses on what was happening for the participant up to the event. The participant who relapses is also asked to attend the Rutland re-entry group, rather than after-care. *Philosophy:* Addiction is an illness and affects every area of life. In order for addicts to stop using two things must occur: • They must come out of denial. • They must gain awareness and insight that they have become addicted. Rutland maintains that anyone who is		participants come from distressed families – families with cycles of crime, abuse and addiction, all are from distressed communities. All have experienced social deprivation and social isolation, and come from "a culture that has little hope for them". *Difficulty in accessing services:* Many participants experienced difficulties obtaining social welfare, or rent allowances and other allowances from Community Welfare Officers. Many experienced severe financial difficulties as a result of being kept waiting for entitlements. Some also had difficulties with housing agencies, for example, Dublin Corporation and Focus Housing. *Health:* Many participants have problems with their teeth, diet, illnesses (contracted while active),	*Note:* The National Drug Strategy Team (NDST) also conducted an evaluation of the programme in early 2000, and the Partnership received notification in mid-2000 that the programme had been deemed a Category A project recommended "to be mainstreamed with no modification required."

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			addicted, whatever the substance, must abstain from all types of mood-altering substances. 'If addiction is there, we see no difference between heroin and prescription drugs.' *Methodology:* Based on the Minnesota Model (an elaboration of the 12 step programme and importance of therapeutic community). Rutland is a residential centre, and the core component of the residential approach is the therapeutic community. Maintenance of the TC is crucial, so clients must agree to abide by five basic rules: no drugs, no alcohol, no gambling, no violence and no sexual contact. *Treatment:* Designed to enhance coping		and generally predisposed to sickness. *Emotional Issues:* All participants experienced vulnerability on completion of treatment. Some people had "huge issues" to deal with. For many it is the first time they see clearly what addiction has done to their families, "and they need a hell of a lot of support around that". *Cross-Addiction:* Most participants from north inner city are chronic addicts and some are cross-addicts. The total abstinence ethos was very difficult for some participants who had not made the link between drugs and alcohol. Many applicants were willing to detox, but not willing to abstain from other mood-altering substances (alcohol, hash and benzodiazepines. Three who relapsed, began drinking on discharge from Rutland).	

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			skills and to help clients achieve personal integrity and inner security, so that a commitment to lasting recovery is possible. *Duration of Treatment:* 6 weeks (twice-daily intensive group therapy, individual counselling, daily lectures/films on addiction/recovery, writing, pastoral care, relaxation therapy, medical examinations, and comprehensive family programme). *After-care:* Available for up to one year on completion of the residential treatment (involves weekly group therapy and optional programmes to meet specific needs). The two counsellors meet weekly to discuss each client's progress, and the director checks in with counsellors		*Lessons Learned (Programme)* *Longer time in pre-entry/part-time Soilse:* Mid-way through programme, decision to keep participants in Soilse part-time for longer (to stabilize and get supports together). Facilitators were too hasty in sending three or four to Rutland, "probably rushed some people who weren't ready, in retrospect…and I think that was a mistake". Engagement with the part-time programme in Soilse creates a stronger link for the participants with the organisation. Moreover, it helps participants understand and see the continuum of treatment in Rutland and rehabilitation in Soilse. A longer time in pre-entry and part-time means participants are monitored better in terms of motivation and preparedness for Rutland. *Stronger assessments:* Assessment procedures in	

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			once a week. There are ongoing discussions about each participant throughout the six weeks, and a final assessment at the end of the time with the director and medical director. This is an after-care assessment, facilitators examine achievements, goals, and what extra forms of counselling they may need. *Reasons for discharge from the programme:* • Breaking the 5 rules (and denial); • Physically unwell; • Possibility of psychiatric breakdown. The programme approach is built around addressing all substance abuse through focusing on the underlying basis of each participant's addiction. The project consists of		the early stages of the programme were "weak" (in terms of evaluating people for Rutland). *More liaison by Soilse with Participants in Rutland:* Little contact between Soilse and Rutland resulted in a weak transition from Soilse to Rutland. It is part of addiction that people become attached to a treatment centre, and experience levels of anxiety leaving it and a disinclination to engage elsewhere. Mid-way through the programme the lack of engagement on the part of Soilse with participants in Rutland, was identified as a gap in the service. There was a need to adjust practice in order to maintain a solid transition from one organisation to the other. Key workers are now introduced earlier in the programme, or participants are given day release from Rutland to attend Soilse. This has	

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			two groups operating on a part-time and full-time basis. The part-time group runs for 8 weeks and is designated for those who are detoxing (either drug free or on methadone) to gauge their suitability, stability and motivation (often referred to as the non drug-free programme). The full-time group, which runs fro 6 months, consists of drug-free participants who attend the programme daily. *The project offers:* • Various relaxation techniques (e.g., shiatsu massage). • Adult education modules that offer accreditation. • Art and creativity classes. • Extensive programme of physical education through using an		resulted in a stronger perception in participants' minds of the line between the two organizations, and because participants are familiar with Soilse they do not experience as much anxiety on leaving Rutland. *Development of stronger group cohesion in Soilse:* Difficulties in forming a strong group on the part-time programme, because of staggered entry into Rutland. In order to promote group cohesion the part-time programme has been made longer. *Lack of referrals:* Issue of small numbers coming forward for the programme. Facilitators claim the methadone-maintenance culture in north inner city does not stimulate people to go for a drug-free option. Rutland Centre rarely gets people self-referring from the north inner city. *Lack of Inter-agency*	

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			on-site gymnasium. *Main therapeutic components:* comprise group and one-to-one interventions with an emphasis on building up skills to strengthen relapse prevention knowledge and techniques.		*Engagement:* The lack of engagement by other organizations with the partnership is noteworthy. There have been few referrals from organizations in the north inner city, with the exception of ICON (six referrals), and not many from statutory agencies (even though Soilse is the social rehabilitation programme of the Eastern Health Board). *Level of Preparedness of Participants:* Facilitators noticed that those who self-refer tend to be stronger in their commitment to recovery and more motivated. Also, participants who have been drug-free longer tend to engage the programme more effectively. *Environmental/Cultural Factors:* All facilitators agreed that the greatest difficulties encountered by participants were the environmental/cultural	

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					factors. One of the strategies put in place to help participants combat these problems was the lengthening of part-time programme and keeping people in pre-entry for longer. *Addiction Education:* All the facilitators spoke about the need for greater education about addiction and recovery in north inner city. The north inner city community has been given, for too many years, a drug-taking answer to the problems of heroin addiction, and find total abstinence a totally alien concept: "the priority given is to methadone maintenance". *Suggestions and Recommendations Improvements to the partnership programme Short-term:* • (Lack of) Rutland after-care group based in north inner city • Fine-tuning of assessments and	

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					screening. • More preparatory work on participants. *Medium Term:* • Consolidate and strengthen the adult education components in Soilse • On-going training for facilitators • More money and resources. • An extension of the partnership into other LDTF areas • More referrals by community groups and statutory agencies • Greater education/stronger emphasis on drug-free outcomes within the north inner city • Family involvement in Soilse • More full-time staff in Soilse *Long-term:* • Development of a youth programme in Rutland Centre. • Evaluation of the programme when	

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					greater numbers have gone through. Resources that need to be funded, and put in place as identified: • A half-way house • Childcare • Support worker(s) *PARTICIPANT PERCEPTIONS OF THE PROGRAMME* *Assessment:* Most participants weren't comfortable going for assessment to Rutland Centre. Ten reported fear, or anxiety. However, all felt relieved at getting in: "I couldn't have seen me last much longer, and a relapse would have killed me". *Challenging Programme:* All found the Rutland programme challenging. Group therapy was cited frequently as the most difficult part of the Rutland programme (e.g. being honest about self and others).	

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					Writing Assignments: Cited as very difficult and challenging (e.g. writing the life-script). *Note:* Although all respondents found the programme very difficult and challenging, most, however, said that they had found it both useful and beneficial to their recovery. The group therapy helped people to talk about themselves, and made many realize they weren't alone in their recovery. *Ex-client talks:* There seemed to be more talks given by recovering alcoholics than drug addicts. *Areas that need attention:* • Tightening up the administration structures • A further examination of the way the NCVA syllabus is being implemented. • Group dynamics	

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					(always difficult to assess, but group cohesion could be strengthened). *Suggestions and Recommendations (Respondents):* Although eleven out of twelve respondents were happy with the programme, suggested improvements include: • A half-way house. • Bigger premises or new buildings. • Crèche, or access to child-minding facilities. • Increased EHB funding for beds in Rutland. • Soilse to open evenings and weekends. • After-hours facilitators. • More publicity about the project ("it should be broadcast more for the work it is doing"). • More organizations like Soilse around the country. • Tightening-up of	

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					Soilse's timetable. • Set up after-care group in Soilse. • Establishment of young persons' group in Soilse. • More one-to-one counselling in Soilse. • More on living skills. • Classes on parenting skills. • Classes in how the work-place functions. • Course in spirituality. • Part-time input into full-time programme. • Speedier transfer to full-time if doing well in part-time. • Provision of proper vegetarian food in Rutland. *Conclusion:* Lack of co-operation and co-ordination of agencies impeded movement towards the integration of services.	
The Soilse-Rutland Partnership programme: an evaluation of the second	Aim of providing a holistic and strategic response to drug abuse based on a continuum of care model utilizing a case management	*No. of Clients:* 25 people from north inner city were assessed; funding was provided for 10 people and 21 'multipliers' also	*Enhancements to Partnership Programme in Phase II:* • Greater overall number of	*Consolidation of the partnership.* *Increased awareness of treatment options in*	*Negative factors affecting participation in the programme:* • Accommodation difficulties (e.g. lack of secure and safe	*Participants Perspectives:* Participants interviewed were very positive about their experiences on the programme. Their

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phase of operation. Independent evaluation of Phase II of the project. *Author:* Anne O'Donoghue, Bernice Donoghue, January 2001.	approach (incorporating care plans), and a total drug-free philosophy. The continuum of care model recognizes that drug addicts have complex needs, and unless a substantial number of these needs are met, the addict will find it very difficult to become and remain drug-free.	engaged with the programme. *Cost of Programme:*. The partnership continued to be funded on an interim basis throughout Phase II. *How Long in Operation:* May-99 – Oct-00.	referrals. • Strengthening of the assessment process. • Consolidation of the Adult Education approach within Soilse. • A more structured implementation of the care plan. • Greater understanding of, and dialogue on the needs of participants. • Greater link-in by Soilse with participants undergoing residential treatment. • A Rutland After-Care group established in Soilse. • Employment of a liaison worker. • The increase in multipliers further strengthening group cohesion in Soilse.	*the north inner city.* The outcomes for participants in Phase II are very positive. Nine of the ten are drug free and one is currently in relapse. Indicators of positive change were very strong re participants' lifestyle changes, accommodation arrangements, family relationships, and in diminished interaction with the Judicial system. *Completion of Programme:* Six of the Phase I participants completed the programme; four did not. However, three of the four remain in contact with Soilse. The majority of NIC Phase I participants are achieving positive outcomes, in particular those who completed the	accommodation). • Lack of childcare services. • Economic factors. • Legal matters/custodial sentences. • Funding restrictions.	comments indicated strong levels of learning and self-development. *Most valuable elements of Rutland Centre's treatment programme (participants):* • Being part of a therapeutic community. • The residential aspect of Rutland Centre's approach. • Family input. • After-Care. Respondents were unanimous that treatment without a rehabilitation component would greatly reduce the chances of recovery. Most emphasized the importance of being able to engage with Soilse as a stabilizing structure at the point of completing residential treatment. *Most beneficial aspects of the Soilse programme (participants):* • A safe place to go to. • Establishing new

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				full programme. *Phase I vs. Phase II of the Programme:* The analysis shows greater success generally for NICDTF-funded participants in Phase II by comparison with Phase I NICDTF-funded participants. This is likely to be related to enhancements to the programme in Phase II that arose out of the implementation of recommendations from the Phase I independent evaluation.		social networks. • Continuity of support on leaving treatment. • Developing communication and interpersonal skills. • Fostering of independence and self-direction. *Drug-Free Status (Phase II):* All eight of the Phase II respondents have a drug-free status. They reported that their understanding of the nature of addiction had changed significantly through what they learned on the Soilse-Rutland programme. The respondents were unanimous that a substance-free approach is the best solution to addiction. • All reported fundamental lifestyle changes. • 2 are in full-time education. • 2 are in fulltime employment. • 2 are engaged with the Soilse full-time

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						programme. • 1 respondent was heavily engaged in family restoration work. *Note:* These lifestyle changes, accompanying the start of the recovery process, are profound, with respondents moving from the chaos of addiction and, sometimes, criminal involvement to re-integration with education, employment and family structures. *Drug-Free Status (Phase I):* Four of the five respondents (NICs and multipliers) are drug-free. The fifth respondent started re-using alcohol after leaving the programme early, but has not used other drugs. Most respondents spoke of a greater awareness of the nature of addiction, in particular, of cross addiction (i.e. the potential for substituting one compulsive addiction with another). The

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						respondents were unanimous that a total drug-free approach is the best solution to addiction. • 4 of the 5 respondents are currently employed. • The fifth is engaged in full-time education. The importance of building social networks was emphasized by respondents. • Respondents articulated expansively on improvements in their self-esteem and progress to self-direction. • Reported ease in their dealings with people now, although some claimed that they feel more comfortable with other recovering addicts than they do with others. • Evidence of greater awareness of health status and issues amongst respondents. *Conclusion:* Soilse-Rutland Partnership

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						programme has established an effective continuum of care. The compatibility of ethos, and complementarity of services, across the service providers have contributed to the effectiveness of the Partnership programme. The programme is an innovative and efficient use of resources. The Partnership programme is a model of best practice. The programme is clearly effective in the short-term. Analysis of the outcomes for participants of Phase I plus the findings from their interviews indicate that the program is effective in the long-term. *Recommendations:* • The Soilse-Rutland Partnership programme should be mainstreamed without delay. • Funding should be provided for childcare provision. • Access to the Soilse-

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						Rutland Partnership programme for those seeking treatment outside the NICDTF be increased. • Promotion of the continuum of care approach. • Funding committed to the provision of secure transitional accommodation. • The SRP model should be replicated in other areas and organizations. • Soilse and Rutland Centre to develop partnerships with other organizations where compatibility of ethos is present. The continuum of care approach, on which the SRP programme is based, provides a pathway to recovery where the likelihood of positive outcomes is increased. Movement toward the integration of services is necessary to enhance the functioning of a continuum of care. It is

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						recommended that the continuum of care model must be promoted by all treatment and rehabilitation sub-committees of LDTFs and adopted by all drug intervention agencies.
Stepping Stones to Change: A Discussion on Rehabilitation, 1999. Author Edited and compiled by Dr. Mary Helen McCann. *Name of Programme:* Stepping stones project of Ballymun Youth Action Team (2000) Note: Not a full evaluation report.	Through an adult education programme, they hoped to provide the opportunity for achievement, raise self-esteem, and increase motivation to change. The basic principles used are adapted from Motivational Interviewing (Miller & Rollnick, 1991). Specific aims were: • To enable participants to build on their levels of numeracy and literacy skills through concentrating on topics and issues relating to their lives, e.g. health, filling in forms, etc. • To build up confidence and self-esteem through participation in a national accreditation	*No. of clients on programme:* 15 people were offered places, 7 on each course. 7 males enrolled in Communications, and 3 females and 4 males enrolled in Personal & Interpersonal Skills. One person was offered 1-1 literacy tutorials because of very low literacy level, and chaotic drug use at the time. *Target group:* People at different stages of drug use (we did not want to mix those new to the drug scene with those who had been involved for a longer time). All interviewees were taking Methadone on a	Two NCVA foundational level modules, Communications and Personal and Interpersonal Skills, were selected after consideration of the NCVA modules available, staff experience and skills (one tutor and one addiction counsellor), and following discussion of the educational experience and level reached by the population of Ballymun in general. Once courses started, a Learning Group began in collaboration with Ballymun Adult Read & Write Scheme. This group did not focus on	None mentioned in report..	*Recruitment:* Of 35 application forms returned, only one person arrived at their appointed time. An indication to staff of the task being embarked upon, and how important it was to remain flexible and person-centred. It was obviously going to be futile to design a programme which demanded daily attendance with people functioning in this way. *Challenges:* With such a group profile, there were many challenges in trying to implement formal learning programmes. Late coming was a constant issue, as was sporadic attendance. However, the place was always available to the	In August 2000 all eighteen people were again contacted to follow up on their progress. Over 80% of them were engaged in something productive – attending other courses, employment, CE schemes, or still attending YAP's course None of them were involved in any such activity before they began the programme. *Changes in participants noted by staff:* • Participants arriving hung over or intoxicated in the early stages stopped happening after a while. • All participants made efforts to improve their personal appearance.

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	system. • Through using education as a tool of development, to encourage evaluation of drug use and its effect on learning. *How define rehab:* To re-establish former good condition; to restore to good health; to restore to youthful and constructive activity. Emphasize the importance of acknowledging that addiction affects all areas of life. If we are to rehabilitate we must look at all the areas. For a person to become addicted it takes a process, therefore we need to see treatment and rehabilitation as being the same. Some processes can be quick, some longer. Rehabilitation means to rebuild or repair. It means starting with addressing the addiction first An understanding	daily basis and all were clients of Domville House. Most people were on prescribed drugs as well as methadone.	any one module, but worked on why we read, characters and story lines. Despite sporadic attendance, five people over nine weeks benefited from this group. During the four months from August to December 1999 a total of 18 people attended the courses for at least one day. 14 were males and 4 were female. Ten of these people also enrolled to continue in January 2000. Six of the eight people who left were engaged in either employment, training, or as in one case, going for residential treatment.		participant, and with many these things improved over the months. *Drug use was a problem:* Tablets being taken during course time, tablets being swapped, people arriving under the influence of drugs, smoking a joint outside, etc. All were issues which arose and were addressed without throwing people off the courses. These issues were eventually challenged by the group itself, a sign of change taking place in their awareness. *Some participant feedback:* 'I would have liked to brush up on my letter writing and feel more confident at writing letters and understanding instructions. Also how to get the main point of a subject'.	• Most of the people who remained with the courses seemed to have built up self confidence in their own ability. A sense of hope for the future built up. People started talking about what they could do in the future • One person applied for the Communication Addiction Studies Course NCVA Level 2). • Opening up – telling staff about their lives past and present, relating the day to day problems they were facing. • Peer support/Education – as people get to know each other the level of support they gave each other increased, as did the level of encouragement. This included support re levels of literacy and personal issues. • *Trust* – after a few months participants began to trust each other more and also the tutors. This led to a

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	of the primacy of addiction means that drugs affect all areas of a person's life, so dealing with the addiction comes before everything else. Rehab should be available for all those in treatment or affected by drug abuse. It should be community based, using local resources and working with individuals and families to create a recovery culture.					greater sharing of information re drug use, relationships, problems and obstacles they face. *Participant Feedback (Some Comments):* 'My probation officer put me on it but after a while I began to like it'. 'I felt good about myself and I wanted to go now and do more.' 'I felt good because I'd seen it through and did what I wanted to do'. 'I feel great about it and what I've done'. 'I did achieve what I wanted to, I finished the course and got drug free'. 'I think I have achieved a lot'. '…now I am off drugs and I am learning a lot more than before' 'I felt I got better at my reading and writing and even my spelling has improved'. 'I recommend doing the course because it will help you with your self-esteem. Doing the course has definitely got me out

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						of a rut. I have stayed off drugs since Christmas and don't feel as paranoid as I did, not as depressed….I have noticed most people stay and want to come on other days too.' 'The course has helped me to become more focused on my work and to become more productive…I am writing much more, getting involved more and I am more assertive since I started this course. So the course has improved me a lot and I really enjoy doing the work.' 'The course made a big difference in my life. It made me feel more confident about myself and that I didn't need all the drugs that I was taking to communicate with people. They helped me understand what I was doing to my family and myself. So I got myself into shape and sorted my drug problem by cutting down on the drugs I was taking.'

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						Conclusion: All three of the original aims of the courses have been touched on by comments of the participants. Although this practice example can only show the progress of a small number of people, it is nonetheless promising to note the progress reported by those who took part. The programme did not actually set out to change drug use, but to create the possibility for this to happen by increasing readiness and confidence. However, we have seen that significant change did actually take place in drug use. An adult education approach, combined with motivational skills and knowledge of drug use, has the possibility to create the space for some change to occur in people's drug use. The participants' interest in learning when met with

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						flexibility and encouragement opened the way to increase confidence in ability to change. Through use of participants' life experience, drug use remained a topic for examination and discussion. Having some formality around the work, i.e. submitting work for accreditation, created the possibility for considering what changes would benefit their lives, and how some of these could be acted upon. Links with other resources in the community allowed some of these actions to be implemented. Group outings to the driving range and bowling, going to a restaurant for a meal were activities which everyone enjoyed, and provided opportunities for social learning and discussion of alternative activities. Characteristics which can be fostered by providers

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						of services for people who use drugs are: *Readiness to Change:* How confident the client feels about tackling their problem. *Examples of Good Practice:* Further examples of good practice need to be recorded, so that creative programmes can be developed to help people at various stages of change.
Tallaght Rehabilitation Project (TRP):A Review Report (Summary Paper 3) *Author* Barry Cullen, Dr. Gemma Cox, Addiction	To get participants to address the causes of their addiction to drugs and to make changes, at a personal level, that would help them get on with their lives. The project aims to help participants return to normality: developing their self-respect and self-esteem, developing basic skills and helping them to deal more	*No. of Clients:* 7. *Target Group:* Adult drug users, drug addicts, former drug users, other stabilized drug users (all substances). *Strategic Target Group/Change Agents:* • self-help group • social workers • former drug users • other: drug project	*Programme:* TRP operates a 12-month, half-daily attendance programme for drug-users: 20 hours per week, mornings, Monday-Friday. The programme is a mix of structured and unstructured practical and therapeutic components. Its primary focus is therapeutic intervention. There are seven members of staff: a manager, senior project worker, an outreach / support worker,	Review primarily concerned with TRP's impact and effectiveness as a local rehabilitation programme; participants' perspectives of the programme. Fieldwork over	*Assessment:* the project needs to use a standardized instrument (of known validity and reliability) such as Maudsley Addiction Profile (MAP) or Addiction Severity Index (ASI) in undertaking assessments. *Monitoring/Review:* the project needs to formalize its contractual arrangements with participants to include written procedures for ongoing monitoring and review. *Involvement of referrers:*	*Contact with Drug Users:* The project is believed to have been in contact, both directly and indirectly with 10% of known problem drug users in Tallaght. *Successful placements:* Of the 30 who commenced the

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Research Centre, Trinity College Dublin *Name of Programme:* Tallaght Rehabilitation Project (2003) Also includes EDDRA Review (2001-02). Process Evaluation (Formative).	effectively with practical issues in their daily lives. It is specifically aimed at drug users whose drug intake has stabilized. The therapeutic model places great emphasis on the importance of routine and structure. It is not concept based but rather has the flexibility that allows the application of a variety of techniques, as appropriate. A greater emphasis on cognitive rather than behavioural change reflects the project's aim to tackle the underlying individual causes of addiction and problem drug use. TRP is clearly not so much concerned with brining about positive behavioural changes as helping to sustain changes that are already achieved and focusing therefore on other forms of personal change. *EDDRA Summary:*	workers *Cost of Programme:* Total budget from 100,000 to 500,000 Euro. Annual budget from 50,000 to 100,000. *How Long in Operation:* Established 01-Oct-99 (on-going programme).	housekeeper and administrative assistant. Initial abstinence based model (abstinence as a programme goal) became less important than that of improving participants' management of their daily lives: a progression that was influenced by participants' own reflections on programme development and which also reflects developments in modern drug treatment literature (Anglin, et al., 2001). An important focus in TRP is to create a supportive, nurturing environment, with daily structure and routine. Participants spend a lot of time working in groups, which have developmental and therapeutic functions (making sense/analyzing information, discussing vocational needs and aspirations). They also explore their history of addiction, identifying internal reasons whey they became dependent and focusing on re-building family relationships and friendships.	seven months, using mainly qualitative method of investigation, in depth interviews (staff, participants and other local stakeholders) and group discussions and participant and non participant observations. Also a quantitative component (basic analysis of records). Perceptions of clients on the usefulness of the programme in helping them to address the nature of their addiction. Perceptions of clients on the project's ability to enable them to effect personal	referrers need to be more actively involved in assessing and monitoring the progress of project participants. : the project needs to develop more options for individual, one-to-one work as an integral component of the daily programme. *Training:* the project needs to build on existing staff training programme to ensure a comprehensive knowledge and understanding of drug treatment and rehabilitation is available. Other broader issues that arise concern the project's mission statement, its use of vocational support programmes, and its continued integration within a local community framework. *Mission statement:* the project needs a new written mission statement that reflects the way in which its practice has developed since it first commenced. The project statement should underline its therapeutic aim of assisting drug users to develop an understanding of their problems and to learn new ways of managing relapse and avoiding a return to problematic forms of drug use.	programme, 19 (14F; 5M) were considered to have been successful placements and of these 9 (7F; 2M) were granted a six month extension of the programme after first 12 months. 5 completed the programme without an extension, 3 left early with agreement of staff, and 2 became deceased during programme. The remaining 11 were considered unsuccessful and either discontinued or were asked to leave the programme. *Participant progress:* Participants emphasize the programme's value in helping them to understand addiction, its

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	To provide a therapeutic service for stabilized drug users that will enable them to return to independent living in mainstream society. TRP has developed the broad aim of providing education and training to participants through a therapeutic process of change, geared towards achieving a drug free status outcome for participants. Specific Objective 1 To attract and maintain stabilized drug users from the Tallaght area into therapeutic treatment. Specific Objective 2 To encourage participants to address the causes of their addiction to drugs and to initiate personal changes that will enable them to develop an independent style of living *Specific Objective 3* To create and maintain a		TRP staff play an important role in group facilitation and maintenance. Staff constantly interact with the group, mostly in a non-directive way, in building motivation. They intervene directly to maintain group safety. Staff are also involved as keyworkers, providing practical advice, encouragement and support. Two members of staff provide in-depth counselling, as required. On a twice-weekly basis participants (clients) come together for relapse prevention groups in which they work together in developing their strategies for avoiding problematic drug use. The group provides a lot of practical peer advice dealing with specific vulnerable situations, personal moments or people. The relapse prevention group is regarded as one of the most important components of the programme. Participants appreciate the group's realism: its acceptance that relapse	changes in their lives The capacity of the project to develop a structured programme (output) on a daily basis for clients	*Vocational support:* The project needs to undertake a deeper appraisal of the vocational dimension to the programme and to explore whether this component provides deeper opportunities for rehabilitation, perhaps through a work placement, whereby participants spend some time either in a work or local service agency. *Local integration:* The community dimension needs to be continued. Alongside a new mission statement the project needs improved physical facilities and a greater integration with other community bodies. *Note:* More prospective research and evaluation to provide quality information to inform future drug policy. The present evaluation data was limited by a retrospective method and collected within a relatively narrow framework and short timescale.	effects on them personally and on the dynamics of family and other relationships. Participants report that they gain this understanding through a process of therapeutic engagement rather than through single therapeutic episodes or events. Through this process participants report that they have dealt with personal issues and also report changes in their confidence, self-esteem, their ability to deal with others and in their capacities to seek further integration within their families and communities. There are indications that participants attribute a lot of

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	supportive, nurturing environment on the project that will enable participants to develop and maintain a degree of structure in their lives. *How define rehab:* The main values of including vocational components in a therapeutic programme are that at completion there is a clear sense of closure, of preparation for work as well as preparation for life.		regularly happens and that occasional use of drugs might not necessarily constitute a major problem. The group is also important in that it helps participants plan and review their progress in rehabilitation in a concentrated, pragmatic manner. *EDDRA Review:* The project was designed to provide a rehabilitation service to 'stable' drug users who were in receipt of methadone treatment at community based drug treatment centres in Tallaght. Existing service providers became aware that there was a need to provide stabilized drug users with a programme of structured psycho-social supports to maintain and build on the progress that clients had achieved through the methadone maintenance programmes. • community programme • reintegration • training. In order to attract and retain clients the project provides a detailed assessment and an			the programme's success to individualized attention and there is a clear demand for more of this. Overall, participants are positive about the programme. They express insight into what has changed for them and they attribute these changes to particular programme elements or staff interventions. EDDRA In its first 18 months of the project's existence, a total of 61 prospective clients 35 Female and 26 Male were referred to the programme. From this number 30 commenced the programme of which 19 were considered to have

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			induction service is offered to suitable clients referred to the project. This has the capacity to identify clients at each stage that may not be ready to engage with the therapeutic process and may require further external support and work. The evaluation found that the project operates on a daily structure with participants arriving and sitting down to breakfast with staff. Then therapeutic work commences in formal sessions through group work and individual work with staff. Participants report that through daily attendance at the project they develop a routine mainly structured around organizing childcare, getting to the project on time for breakfast and gradually creating a daily structure in their lives that contrasts sharply with the chaotic nature of their drug-using experiences. *Approaches:* • Community Programme • Reintegration • Training. *Setting:* Urban, Community,			been successful placements. Overall the project is believed to have been in contact, both direct and indirect, with 10% of the problem drug using population in Tallaght. An evaluation of the project in 2002 found participants reporting to have gained an understanding of their addiction through the therapeutic process utilized by the project. In addition, many report positive changes in their confidence, self esteem, their ability to deal with others and in their capacities to seek further integration within their families and communities.

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			Out-patient setting (specialized). TRP operates a 12 month, half day morning programme for drug users lasting 20 hours per week from Monday to Friday. The project is operated by 7 members of staff. The project primarily draws on the explanatory framework of Social Learning Theory (Bandura 1977) to account for the development of drug addiction/dependency among its target group. *Actions:* • adventure • advice and support • alternatives to drug use • care • counselling • day care • education (skills, abilities, etc.) • group therapy • long-term treatment • newsletter • referral point • rehabilitation • reinsertion/social insertion • safe-sex counselling			Of the 30 who commenced the programme, 19 (14F; 5M) were considered to have been successful placements and of these, 9 (7F; 2M) were granted a six month extension of the programme after first 12 months.

SECTION THREE

DRUG REHABILITATION

SERVICES IN EUROPE:

A REVIEW OF A SAMPLE OF

PROJECT EVALUATIONS

Drug Rehabilitation Services in Europe: a review of a sample of project evaluations

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North West Lancashire Day Reintegration Service, UK.	1999	14 - 17

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Austria *Name of Programme:* Vienna Job Exchange, Association for the vocational integration of persons who are addicted to (pharmaceutical) drugs and/or alcohol, 2001.	*Aims:* Re-integration of addicts into the labour market based on the principle of an integrating drug policy. *How Define Rehab:* The Vienna Job exchange exists to reintegrate drug addicts into the labour market by offering assistance, counselling and support in gaining qualifications. *Specific Objective 1:* Reduction of obstacles preventing re-integration into the labour-market (e.g. current substance abuse, debts, criminal records, long term unemployment, lack of qualification, etc.) by provision of assistance, counselling and support to acquire additional qualifications, which are important for professional life. At the end of the intervention either the provision of a job/employment (through intensive guidance for re-integration into the labour market) or of a	*No. of Clients:* On an annual basis 1000 clients make use of the service. Final target group: 950. *Target Group:* Adult experimental drug users, drug users, drug addicts, persons with drug-related health problems, persons with drug-related legal problems, former drug users, comorbidity clients (all substances). Estimated to be about 1200 persons. *Strategic Target Group/Change Agents:* • social workers • psychologist • health professionals • former drug users • NGO's/Non-governemental organizations/Voluntary organisation • criminal justice staff : probation • Other : Labour market counsellors *Cost of Programme:* No data provided.	*Programme:* 2/3 of clients receive support in gaining a qualification or employment and 1/3 of clients are referred to treatment. *Background:* During the 1980s it was found that "the vocational integration of ex-addicts is a problematic field, ... If the vocational integration is restrained or fails, the often expensive treatment successes of addicts are jeopardised." (Springer 1984). Also, surveys showed that lack of adequate choices for vocational reintegration existed. (Especially in regard to those requiring intensive guidance due to additional concerns such as health problems and criminal records. The inception of the first Viennese drug-concept started in 1992, including the organisation of integrative measures. In 1992 all these facts led to the foundation of a counseling centre which	*Evaluation Indicator 1:* Statistics of results and original data: Results of counseling. *Evaluation Results 1:* Annually about 1000 clients make use of the services of the Vienna Job Exchange; most of them had been unemployed for 3 to 9 years before the intervention. Due to the intervention and the networking with other specialised institutions nearly two third of the clients can: • reach stabilisation and motivation for abstinence, • take up an occupation (again) resp. a qualification • re-integrate in the labour market. The remaining third of the clients are transferred to relevant counsellling resp. treatment institutions. *Evaluation Indicator 2:* Retrieval of social-anamnesis data. The results of the		*Meeting Client Needs:* The Vienna Job Exchange managed to meet the different needs of its clients by offering individual and time-consuming counselling. Analysing the vocational progresses of the clients of The Vienna Job Exchange shows a reduction of occupational activities before the start of counselling by The Vienna Job Exchange and a constant increase of occupational activities after the end of the assistance. The Vienna Job Exchange is well known in its field, which facilitates networking with other involved institutions. The quality of co-operation with institutions of the Labour Market Service, treatment and other counselling institutions was found to be very good.

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	qualification measure (training, etc.) should be ensured. *Specific Objective 2:* Improvement of social skills and of motivation for vocational re-integration *Basic Assumption:* The learning of social skills in taking up a profession or participating in gaining a qualification produces more self-esteem and works as motivation for unemployed clients to try to get a job again.	*Annual Budget:* From 100.000 to 500.000 Euro. *How Long in Operation:* Established 01-Jan-00 (on-going programme).	on a voluntary basis, for addicted persons as well as for persons with therapy experience, provides individual vocational plans for re-integration, helps with the realisation of those plans, and offers guidance and aftercare. *Approaches:* • Vocational rehabilitation • Community programme • Reintegration • Workplace approach *Settings:* • Urban area • After care setting: work • Out-patient setting: specialized. *Basic Assumptions:* Reduction of obstacles preventing re-integration into the labour-market (e.g. current substance abuse, debts, criminal records, long term unemployment, lack of qualification, etc.) by provision of assistance, counselling and support to acquire additional	evaluation showed that the chance of occupational re-integration is increasing in correspondence to the frequency of use of the services provided by the Vienna Job Exchange: The more frequently the clients used the services, the more likely they were to find an occupation in the first labour market. Discontinuations happened mostly after the first contact. The more often the clients used the service, the more often The Vienna Job Exchange was informed about the final result of the counselling. Therefore, we may conclude that the social skills and motivation to work could be increased in the course of more frequent use of the services provided by The Vienna Job Exchange. *Qualitative Results:* Each of the involved groups (clients, units of the Labour Market Service, treatment and counselling institutions)		

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			qualifications, which are important for professional life. At the end of the intervention either the provision of a job/employment (through intensive guidance for re-integration into the labour market) or of a qualification measure (training, etc.) should be ensured. *Services:* • A counselling institution for the vocational re-integration of people experienced with addiction (alcohol, pharmaceutical products, drugs). • Serves as a link between institutions treating addicts and institutions of the Labour Market Service. *Client Requirements:* • personal motivation, • a stable social surrounding and the will for a continuous medical, psychotherapeutical, psychosocial treatment.	reported to be content with the offers and the mode of working of The Vienna Job Exchange; besides, they perceived the services provided by The Vienna Job Exchange as a relief for their own work. *Evaluation of the Programme Planning:* Assessment of the situation and the appropriate measures and strategies to be used for the programme. *Process evaluation (formative):* Measurement of the quality and intensity of the programme implementation and the acceptance of the programme among the participants. *Summative evaluation (outcome and impact):* Measurement of the results in terms of outcome -degree of achievement of objectives. *Type of Evaluator:* external evaluator (Ludwig Boltzmann-Institute for addiction		

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			Specific Services: • Supports a start or re-start of vocational life, • Offers counselling in the field of vocational orientation and job-finding, • Informs about actual possibilities of qualification and promotions by the labour market service, • Offers individual help to gain the wanted vocational aim, • informs about possibilities of inpatient and outpatient deprivation-treatment, • allows the use of its infrastructure for the independent search for a job, • accompanies during the start phase into the vocational process. Due to the intervention and the networking with other specialised institutions nearly two third of the	research).		

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			clients can reach stabilisation and motivation for abstinence, and take up an occupation (again) resp. a qualification, • re-integrate in the labour market. The remaining third of the clients were transferred to relevant counselling resp. treatment institutions. Annually, about 1000 clients make use of the services aiming at the following goals: • Reduction of obstacles to the integration into the labour market (e. g. current substance abuse, debts, criminal records, long term unemployment, lack of qualifications, etc.) by provision of assistance, counselling and support to acquire additional qualifications, which are important for professional life. • At the end of the			

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			intervention either the provision of a job/employment (through intensive guidance for re-integration into the labour-market) or of a qualification measure (training etc.) should be ensured. · • Improvement of social skills and of motivation for vocational re-integration. In 1995 an external evaluation of the Vienna Job Exchange took place, being part of a study; an internal evaluation takes place permanently. *Actions:* • Work training/testing • Networking and making contacts • Betreuungseinr • community work • counselling • crisis intervention • lobbying • reinsertion/social insertion • work training/labour training			

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			Special Remarks: • Services are not just available for persons who already finished a drug treatment programme but also for clients in substitution treatment or with acute drugs and/or alcohol problems. • Assistance takes place on a voluntary base. It's a principle that the institution is open for people of every age and professional group in the Viennese region. If clients who are also in care at other (i.e. drug related) institutions agree, the results of the counselling are reported to these institutions to help avoiding possible interference between different interventions. • Often, treatment institutions send their clients for a single contact to The Vienna Job Exchange and use			

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			the result for their own plan of care. • Annually, about 1000 clients make use of the services; the ratio between men and women is 70:30 and is nearly constant over the years. • Most of the clients were unemployed for three to nine years before using the services of The Vienna Job Exchange. • Most of the clients are in the age-groups 30 to 40 as well as 26 to 30 years. • The clients come from all professional and social groups.			
Italy *Name of Programme:* Operational Programme: Therapeutic Work Placements For Drug Users In Treatment With The Drug Dependency Services Of Local Health Agency 11. *Responsible Organisation:* Drug treatment service	*Aims:* The objective of the programme was professional activation of long term unemployed drug dependent clients of the drug treatment services (i.e., to improve professional competencies). *Rationale:* Therapeutic experience has shown	*No. of Clients:* 21 clients completed the training course in 1999; and 21 in 2000. *Target Group:* Long term unemployed adult drug addicts (all substances) of the drug treatment services. *Strategic Target Group/Change Agents:*	*Programme:* A support programme that helps drug users get back into employment. *Background:* The programme was developed based on the good results achieved from analogous experiences in the course of the therapeutic work of the agency	*Attendance:* Attendance at the course; number of participants completing the course: • 21 in 1999 • 21 in 2000. *Take up of regular employment:* • 21 insertions achieved in 1999 and 21 in 2000. • 16 in local		*Work Placements:* Up to 2000 42 therapeutic work placements had been initiated (21 in 1999 and 21 in 2000): 27 (64,3%) men and 15 (35,7%) women. *The placements were undertaken in:* • Local Authorities 16 (38,1%),

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of Empoli and Fucecchio of the local health agency 11, 2004.	that placing drug dependents in treatment into work guarantees the survival and continuity of both affective relationships and of social life. Moreover, employment pushes clients to improve themselves, thus it becomes an agent supporting rehabilitation and preventing relapse to drug use. Finally, clients move from just receiving help to becoming the principal actors in achieving their own changes. *Specific Objective 1:* Professional training of clients, stimulating them to attend the training courses organised by the Training Agency of Local Health Agency 11, or giving economic incentives to participate in other training courses. *Specific Objective 2:* Employment placement of drug dependents in public agencies, and/or local authorities and/or private workshops, though the drawing up of a convention.	Social Workers. *Total Cost of Programme:* No data provided. *Annual Budget:* From 50.000 to 100.000 Euro. *Sources of Funding:* National Government 100%. *How Long in Operation:* Established 01-Oct-98 (on-going programme).	proposing the project. *Approaches:* • Substitution programme; • Reintegration; • Treatment. *Settings:* • Urban area • After-care setting (educational) • After-care setting (work) • Out-patient setting (specialized). *Main components:* The programme was carried out through therapeutic work placements in public services, Local Authorities or private workshops in the Communes served by Local Health Agency 11 the neighbouring areas. The programme used social workers and professional educators under the direction of the head of the drug dependence service. Each year the programme had a preparatory course (5 meetings for a total of 10 hours) for tutors who	authorities, 6 in social enterprises (ONLUS) and 20 in private agencies. *Number of people drug-free, number of offences committed during the courses and insertion into employment:* • 41 clients remained drug free. • None committed offences. *Qualitative Results:* • 39 clients (92.9%) always respected the working hours. • 34 clients (81%) were registered with the Unemployment Office. • In all clients an improvement in family relations and a resumption of their role in their own family was observed. *Evaluation of Programme Planning:* Assessment of the situation and the appropriate measures and strategies to be used for the programme. *Process Evaluation*		• Associations 8 (19.0%), • Private bodies 18 (42.9%). *The results to the end of 2000 have been:* • regular employment 9 (21.4%); • objectives achieved 5 (11.9%); • interrupted 5 (11.9%); • in progress 23 (54.8%). *Indices of verification:* • 41 (97.6%) remained drug-free; • 39 (92.9%) respected the hours and the rules; • 41 (97.6%) committed no offences connected with drugs. In all clients an improvement in family relations and a resumption of their proper role in their own family was observed.

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	Specific Objective 3: Keep clients drug-free; avoid committing offences.		had the responsibility of accompanying clients in the experience and facilitating their socialisation to it. After having chosen the type and place of work with the social worker, the clients placed signed a contract to respect certain fundamental rules, the first being abstinence from drug use. The rehabilitation progress was monitored and verified through: • the relationship between the number of abstinent clients and those placed; • the relationship between the number of clients regularly present at work and those placed; • the relationship between the number of clients committing offences and those placed; • the relationship between the number of clients who ended their therapeutic placement with regular work and those placed.	*(Formative):* Measurement of the quality and intensity of the programme implementation and the acceptance of the programme among the participants. *Summative evaluation (outcome and impact):* Measurement of the results in terms of outcome -degree of achievement of objectives. *Evaluation tools and resources:* • Urine testing, • Verification of the place of work, • Reports from interviews with employers, attendance register, • Verification meetings, • Reports from tutors. *Type of Evaluator:* Internal Evaluation.		

Title of Evaluation	*The aims of the project/How define rehab*	*No of clients/Target Group/Cost of programme /How Long in Operation*	*Main components (e.g. key worker involvement, case planning/ management)*	*Outcomes (measures used to evaluate)*	*Challenges faced in implementing/ limitations of programme*	*What they see as constituting success*
			Actions: • advice and support • methadone maintenance • out-patient detoxification • rehabilitation • teaching/training • work training /labour training.			
Netherlands *Name of Programme:* Individual Support And Placement To Obtain A Competitive Job For Former Addicts. *Responsible Organisation:* Netherlands Institute of Mental Health and Addiction (Trimbos-institute). *Bibliographic Reference:* Michon, H., M. Rondez, J. van Weeghel: Een werkend model. Utrecht: Trimbos-instituut, 2000.	*Aim:* Programme target is to support and place 70 former drug addicts in a competitive job within 3 years (minimal 15 hours per week for minimal half a year during a period of nine months). This job has to be subsidised (supported employment by the national government, etc.) for maximal one third in cases were a fully paid competitive job is not feasible. *Specific Objective 1:* To stimulate co-operation between organisations of addiction care, local and regional social services, and the Employment Office. *Specific Objective 2:*	*No. of Clients:* 136. *Target Group:* Adult drug users, drug addicts, persons with drug related legal problems, and former drug users (all substances) who are: • registered citizens in two cities in North-Holland (Haarlem en Alkmaar); • entitled to social benefits and housing; • registered by the Employment Office. *Note:* Excluded are clients with severe mental illness, included are those with dual diagnosis. *Strategic Target Group/Change Agents:* Teachers/educators;	*Programme:* Supports former drug users back into employment. *Approaches:* • Community programme; • Reintegration; • Treatment. *Settings:* • Rural and urban. • After care setting: work • Out-patient setting: general services. *Programme Details:* Workshops. *Actions:* • Advice and support • Arranging talks and Speeches • Care • Community work • Liquidation of debts	*Evaluation Indicator:* Having a regular paid job after participating in the programme for several months: • Satisfaction with the work situation. • Satisfaction with this programme. • Utility of this programme (opinions of participants and professionals). *Evaluation Result:* Leaving this support and placement programme is caused by: • Having found a paid job (expected 48% in July 1997); • Relapse (using drugs again) or • By moving out of the region.	Supportive action for (former) drug addicts to find work is incidental. For this group it remains more difficult to succeed in finding a paid job compared with non addicts. Municipal and regional social services are formally responsible for former addicts (beneficiaries and job-seekers) to support or assist them to competitive jobs. Co-operation between these organisations should be enhanced for this target-group. *Risk or protective factors are:* • Stagnation of eligible numbers that want to participate in this programme,	During the period Jul-95 to Jul-99 72 participants left the programme. • Thirty-one (43%) found a paid job (competitive or subsidised). • Two-thirds of the 31 found a (regular) competitive job on the labour market. • Self reports show that the situation of 60% of clients has improved (both workers and those who did not find jobs yet).

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	To determine risk- and protective factors for supported employment will be determined to increase the success of future programmes *Specific Objective 3:* To decrease public nuisance caused by addicts. (*Assumption:* Having a paid job decreases drug-related nuisance). *How define rehab:* To join the labour market by getting a paid job will decrease relapses and consequently also drug related nuisance. Successful individual support and placement will stimulate co-operation of several organisations that have an interest in this.	Social Workers. *Cost of Programme:* No data provided. *Annual Budget:* From 50.000 to 100.000 Euro. *Source of Funding:* National Government (25%), NGOs/Voluntary Organisations (75%). The Brijder Foundation and the Ministry of Health, Welfare and Sport have funded this project. *How Long in Operation:* Established 01-Jul-95 (on-going programme).	• medical treatment • other • rehabilitation • teaching/training • work training/labour training.	Self reported (qualitative) answers of professionals of the organisations show that co-operation between the stakeholding organisations has improved and thus the chance of getting a job has increased. *Type of Evaluator:* External evaluator.	• deficits in following the clients in the process of finding and getting paid work, • shortage of personnel, • low quality of reporting data (programme plans, process reports). *Measures of Public Nuisance:* A decrease in public nuisance could not be measured. Current publications show that public nuisance (and for drug related nuisance this is even more true) is difficult to quantify, and dependent on for instance the presence of night shelters for addicts, behaviour of police officers, or presence of nuisance reporting facilities. *Qualitative Results (Referrals):* Influx of new clients has decreased (there is no explanation given). *Programme Planning:* No evaluation of programme planning.	

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UK *Name of Programme:* North West Lancashire Day Reintegration Service, New Start Trust. *Bibliographic References Related to the Programme:* • Andy Jones and Tim Millar. University of Manchester Drug Research Unit. NewStart: North West Lancashire community reintegration service. Evaluation of the project's first year. • New Start Trust. North West Annual report. 1999/2000.	*Aims:* Newstart seeks to provide a holistic approach to drug users who wish to reduce their drug use and ultimately reach abstinence. *Rationale:* Need for a drop-in centre to provide a safe and constructive environment as a complimentary service to existing agencies. *Specific Objective 1:* Treatment accessibility – all service users should have access into the community projects within three working days, assessed and offered and individual care-plan. *Basic Assumption 1:* Drug use and misuse does not occur in a vacuum. There are many personal and social factors that underpin a person’s behaviour in relation to substance misuse and these must be taken into account when considering treatment option. For example, it is often difficult to reach and maintain abstinence	*No. of Clients:* 214. *Target Group:* Adult drug users and drug addicts (all substances, opiates). *Strategic Target Group/Change Agents:* Social Workers. *Cost of Programme: Total budget:* from 500,000 to 1,000,000 Euro. *Annual Budget:* from 100,000 to 500,000 euro. *How Long in Operation:* Starting date: 01-May-98. End date: 01-May-01. On-going programme since 01-Jan-01.	Newstart provides a range of services and supports positive behavioural changes by working with drug users, their families and the community. The service therefore runs a five-day drop-in center, which provides drug users and their families with a range of services. *A Safe Place To Go:* First of all, it provides a safe place where drug users can go, and feel supported in their efforts to come off drugs. It is recognized that drug users coming off drugs are in a difficult position socially. They have to turn their back on their former support networks if they wish to avoid relapse, yet have no other set of contacts or friends. Often they have long lost touch with their family, and have no external structures, such as provided by work or further education. *Day-Centre:* The day-centre seeks to fill this gap, which is regarded as a major impediment	*Evaluation Indicator 1:* • Number of clients referred to the project, • Number of clients attending for first contact, • Number of clients for whom assessment was completed, • Number of clients accepted on to the programme, • Number of clients for whom an assessment review was competed at first and third month, • Number of clients who completed programme, • Number of clients known by staff to have entered education or employment. *Evaluation Result 1:* • A majority of contacts resulted in an assessment for inclusion on the service programme. • Selection of clients for assessment appeared to be a major filtering process in itself, as most individuals who	*Inappropriate Referrals:* Referrals from the probation service and from GPs stand out as the most likely to be inappropriate. • One half of the accepted programme clients lost contact within one month. • Analysis of defaulters versus continued attenders reveals that area of residence has a significant impact on length of attendance, such that Wyre&Fylde residents were the least likely to remain in contact until the first review point. Given that as many attend from Wyre&Fylde as from Preston, this may be an issue that requires further attention. • The overall numbers recorded as achieving goals were very small compared to the numbers starting the programme. • Very few goals	• Nobody had injected in the previous four weeks. • Most clients wanted to achieve abstinence. • Among those who attended up to the third point of review, a third achieved their goals, increasing to two thirds of those whose goals related to employment. • Distinct changes were observed among the interview sample over three months from initial attendance. For most, problematic drug use was reduced, although relapses were reported. *Qualitative Results:* • 50% of those followed up described themselves as employed. • Clients were engaged in constructive, non-drug related entertainment in a variety of ways. • Clients portray the service as being characterised by

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	when ones' peers and neighbours are chaotic drug users, so new social contacts must be made and sometimes it is necessary to move house. The service at New Start – North West is intended to facilitate the reintegration, by leading clients to accessing mainstream opportunities for themselves. *Specific Objective 2:* Positive changes in health, social situation, substance misuse, offending behaviour and quality of life. *Basic Assumption 2:* Drugusers are often emotionally volatile as consequence of their substance misuse. Moreover, many users live chaotic lifestyles where they are no longer in control of their time, and are no longer in the habit of planning ahead. The admission of having a problem, and turning towards and institution for help is therefore a delicate and important moment. Help is		to both reducing drug use and to staying drug free. *Client Involvement in Running Project:* The project endeavours to involve its clients in the running of the project. This reinforces their commitment, as well as providing ex-users with a valuable social role. Working with other ex-users is also helpful in establishing a social group to provide an alternative to the drug use networks. *Range of Therapies:* In addition the centre offers a range of therapies, including counselling, including electro stimulation, groupwork and diversionary activities. *Nutrition:* Recognize that many long-term drug users are living on a poor dietary regime, the physical symptoms of which can often be mistaken for withdrawal symptoms. Hence, food provided by the service.	were assessed for the programme were actually taken on. • Although many clients remained with the service for only a short period, which is not unusual with this client group, others have maintained contact and have started to make changes in their lives. *Type of Evaluator:* External Evaluator.	were set at the three months stage. • In working towards their goals, clients relied on staff and peers. • Clients were more likely to engage in recreational drug use at three months, having re-socialised into a culture in which cannabis use is very common. • No evaluation of programme planning.	helpful and understanding staff and like-minded clients

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	expected instantly, in a way similar to the instant gratification offered by substances. Any delay in the provision of drug treatment, therefore, is liable to discourage the client, and encourage him/her to relapse. *Specific Objective 3:* To fill the gap of excessive spare time of recovering drug users. *Basic Assumption 3:* A person whose life has revolved around drugs with a constant need to fund their dependency may often find themselves with considerable time on their hands when they make the decision to change their lifestyle; diversionary activities are needed otherwise the temptation to relapse becomes unendurable. Relapse prevention continues to form the cornerstone of our services helping clients to lead healthy substance free lives. We offer the additional support that will enable clients to		*Advice:* Practical advice is offered to help clients in taking control of their lives. Giving assistance in obtaining housing, social security, and education, is aimed at reintegrating former drug users in society. *Care Planning:* Each client is seen by an agency worker, who will assist with the drawing up a care plan for the service user. This care plan will set goals for the client, culminating in achieving abstinence. *Staff/Personnel:* The day integration service employs a fulltime manager, two full time and one part time project worker, three sessional workers and two part time administration workers. There are six volunteers one of whom is an ex client of the service who, having completed a counselling course and remaining drug free for twelve months now works alongside a skilled and experienced project worker in the			

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	fully reintegrate themselves back into mainstream society.		Peer support Group. *Approaches:* • Low threshold services • Reintegration. *Setting:* • Rural. • Out-patient setting (specialized). *Actions:* • advice and support • counselling • day care.			

SECTION FOUR

REVIEW OF RESEARCH

REPORT ON "AN EXPLORATION OF

DIFFERENT MODELS OF

MULTI-AGENCY PARTNERSHIPS

IN KEY WORKER SERVICES"

Review of Research Report

"AN EXPLORATION OF DIFFERENT MODELS OF MULTI-AGENCY PARTNERSHIPS IN KEY WORKER SERVICES FOR DISABLED CHILDREN: EFFECTIVENESS AND COSTS"

Veronica Greco, Patricia Sloper, Rosemary Webb and Jennifer Beecham, Social Policy Research Unit, University of York, 2005.

Executive Summary

Role of the key worker

- The key worker is described as a named person whom the family can approach for advice about, and practical help with, any problem related to the disabled client.
- Up to now, research has shown that less than a third of families with severely disabled children have a key worker, but compared to those who do not have a key worker, those who do show benefits in terms of relationships with and access to services and overall quality of life.

Chapter 1: Background

Role of the key worker

Drawing on evaluations of key worker projects in three local areas (Mukherjee *et al.*, 1999; Tait and Dejnega, 2000), a number of points can be made about the role of key workers. Both key workers and families reported that the role of the key worker encompasses:

- Providing information and advice to the family.
- Identifying and addressing needs.
- Accessing and coordinating services for the family and ensuring their timely delivery.
- Providing emotional support.
- Acting as an advocate for the family.

The balance between these activities will differ for different families and at different times in a family's life. This underlines the importance of the service being flexible and responsive to families' views and needs.

Factors affecting the provision of key worker services

- In order to provide a co-ordinated service to families, key worker systems must involve active partnerships between different agencies. Social Services Departments, Local Education Authorities and schools, NHS Trusts and Primary Care Trusts are central to this partnership, but families' needs also encompass the roles of voluntary agencies, housing departments, leisure services and the Benefits Agency (Dobson and Middleton, 1998; Beresford and Oldman, 2000; Beresford, 2002). The role of the key worker involves liaising with and coordinating support relating to these different agencies.

- Research on inter-agency working in services for children and young people points to difficulties encountered in terms of different professional cultures;

funding structures; potential overlap of roles; lack of understanding about the roles and responsibilities of different agencies; ensuring commitment of staff within the different agencies; communication both within and between agencies; and differing concepts regarding confidentiality of information (Dyson *et al*., 1998; Sloper *et al*., 1999; Coles *et al*., 2000; Atkinson *et al*., 2001; Webb and Vulliamy, 2001). There are indications that the different responsibilities and structures of agencies involved in services for disabled children can also present barriers to cooperation. For instance, ensuring that LEAs and schools are partners in a coordinated inter-agency approach can pose particular problems in relation to the autonomous status of schools (Webb and Vulliamy, 2001).

- A number of factors appear to work against the implementation of key worker services (Sloper *et al*., 1999; Beattie, 2000):
    - If key worker services are to be part of the service system, implementation must take place on an inter-agency basis. Therefore dependent on a basis of good multi-agency working at both strategic and practice levels. However, this was under-developed in many areas.
    - Key working is underpinned by collaboration between different disciplines. Lack of trust between disciplines undermines this.
    - The role of the key worker is different from the usual professional roles. In some professions, a priority is to provide focused, time limited, task oriented solutions, directly aimed at specific problems and goals. In contrast, a key worker has a longer-term and proactive role, covering a variety of issues and problems that cut across disciplines and agencies. This can challenge existing professional cultures.
    - The role of a key worker currently carries no status.
    - Current referral systems and lack of funding are also barriers.
    - Implementing a key worker service is about changes which challenge current patterns of work.

More general research on multi-agency working also provides consistent findings on factors that can facilitate or act as barriers to coordination of services (for example, Watson *et al*., 2002b; Cameron and Lart, 2003; Sloper, 2004). At the organisational level, key factors facilitating joint working have been found in the planning, implementation and ongoing management of multi-agency services.
In planning service, studies suggest successful multi-agency working is promoted by:

- Clear and realistic aims and objectives understood and accepted by all agencies, leading to a clearly defined model of how the multi-agency service will operate.
- Agreement about how resources will be pooled or shared.
- Clearly defined roles and responsibilities, so everyone knows what is expected of them and of others, and clear lines of responsibility and accountability.
- Commitment of both senior and frontline staff, which is aided by involvement of frontline staff in development of policies.
- Strong leadership and a multi-agency steering or management group.
- An agreed timetable for implementation of changes and an incremental approach to change.
- Linking projects into other planning and decision-making processes.
- Ensuring good systems of communication at all levels, with information sharing and adequate IT systems.
- Involving service users in development and evaluation of the service.

Research suggests that implementation and ongoing management of service requires:

- Shared and adequate resources, including administrative support and protected time for staff to undertake joint working activities.
- Recruitment of staff with the right experience knowledge and approach.

Interestingly, Atkinson *et al*. (2002) found that many of those involved in the multi-agency initiatives had worked in multiple agencies during their career, suggesting that a new type of 'hybrid' professional may facilitate joint working.

- Joint training and team building, and 'time out' to take part in these activities.
- Appropriate support and supervision for staff.
- Monitoring and evaluation of the service, with policies and procedures being reviewed regularly in the light of changing circumstances and new knowledge.

Studies also highlighted that professional and agency cultures can facilitate joint working: understanding, respecting and valuing the roles of other professionals is important and can be promoted by joint training.

Factors that hinder joint working include:

- constant reorganisation;
- frequent staff turnover;
- lack of qualified staff;
- financial uncertainty, difficulties sustaining initiatives when funding ceased and difficulties in ensuring equity from partner agencies; and
- different professional ideologies and agency cultures.

However, although considerable body of research on the process of multiagency working, there is a dearth of evidence on outcomes for service users of such models of working (Cameron *et al*., 2000; Watson *et al*., 2002b; Sloper, 2004).

Aims of the research

- To compare implementation and operation of different models of key worker services.
- To assess outcomes for parents and children of provision of different models of key worker services.
- To investigate sources of funding and costs of different models of key worker services.
- To identify the features of the services that contribute to improved care for disabled children and their families.
- To inform standards of good practice in services for disabled children and their families.

Methodology

Seven services representing different models of key working were selected for detailed case studies, comprising interviews with staff and families and questionnaires to all families receiving the services. Data analysed quantitatively and qualitatively.

Key findings

Key messages for policy and practice from this research are summarised below:

- Key workers provided a valuable service for families and had positive impacts on many families' lives. Key workers' collaborative work with other agencies and professionals facilitated access to appropriate support for disabled clients.
- However, outcomes for families varied between and within areas. Factors

relating to better outcomes included management of the service, definition and understanding of key worker role, and provision of training and supervision for key workers. The findings have a number of implications for the further development of key worker services.

Management of the service

- Results found key worker services provide the most benefit to families when effectively managed, and when health, education and social services are all committed to the service and provide adequate resources in terms of funding, staff and managerial support.
- A multi-agency steering group, involving senior managers from each agency, who have power to commit resources, should oversee the service, facilitate information sharing and agree ways in which the service will gain families' consent for information relating to them to be shared between professionals and agencies. The involvement of parents in the group helps to focus on the needs of families.
- At a minimum, funding required to cover the time of a dedicated service manager and some administrative support. Such funding should be agreed on an ongoing basis. Short term funding produces uncertainty for staff and families and increases fragility of the services.
- The service manager's role should include:
    - inducting key workers,
    - organizing ongoing training and opportunities for key workers to meet together,
    - ensuring key workers are provided with regular supervision specific to their role,
    - organising joint care planning and review meetings, and drawing up information about the service and publicising the service to families, other agencies and professionals.
- If non-designated key workers (i.e. workers who key work with a few families in addition to their normal professional role) are employed, it is important that they have protected time to undertake the key worker role and that this is recognised in their case loads. Part of the role of manager and of steering group members is ensuring that line managers in agencies from which key workers are drawn understand the role of the key worker and are committed to the key worker service. The time commitments of the role should be recognised and agreed between the service and the agencies that provide key workers.
- Multi-agency care planning and review meetings should be part of the service. These provide a valuable means by which actions of different agencies and professionals can be agreed in collaboration with parents and, hopefully, young people. Such meetings are also an important part of information sharing. Key workers should support families to prepare for and take part in these meetings. Whenever possible, meetings should be combined with other reviews, such as statementing reviews, so that families are not required to attend multiple meetings.

Key worker role

- In some areas, there was confusion about the role of the key worker among families and key workers themselves. The most effective services had clearly defined the role and ensured that both key workers and families understood what it covered. Outcomes for families were strongly related to the extent to which key workers carried out the different aspects of the role.
- A definition of the role of key worker should be drawn up and incorporated in a job description. The service manager should ensure that every key worker

understands the role. Information for families should also make clear what is and is not within the key workers' role and key workers should explain this to families. Families should have written information about the role to refer back to. Other services in the locality, should receive information about the key workers' role, and key workers and service managers should be proactive in ensuring that relevant professionals know about, and understand the remit of, the service.

- Best outcomes for families are achieved when role of key worker includes:
    - providing information to families about services and support available; both locally and nationally, and how to access these;
    - providing information about the child's condition where needed;
    - identifying and addressing the needs of all family members;
    - coordinating care and supporting families with care planning and review;
    - improving access to services;
    - speaking on behalf of the family when dealing with services;
    - providing emotional support; and
    - providing help and support in a crisis.
- Extent to which key worker carries out different aspects of role will depend on particular needs of each family.
- Key workers should be proactive in contacting families regularly at intervals agreed with the family.
- Key working is a service for the family, not just parents. Key workers need training to support them in working with disabled children and young people, particularly those who have cognitive and/or communication impairments. In addition, time is needed for key workers to ensure this work can take place. Children and young people's participation in decisions about developing the service should also be promoted, again this will need time, resources and support for children.
- Key workers have a 'hybrid' role that requires a broad range of skills and knowledge. The research showed that it is performed best when it is not an add-on role without time and training allocated to it.

Key worker training and supervision

- Key workers who received regular training, supervision and support were likely to carry out more aspects of key working and had more positive impacts for families.
- Key workers require induction and ongoing training specific to their role. This should include information about:
    - The work of all agencies relevant to disabled children and their families, common disabling conditions, relevant legislation, and sources of financial support for families and eligibility criteria.
    - Training should also cover disability awareness and the personal skills needed by key workers – communication, listening and negotiating skills, communicating with disabled children, and time management.
- Key working is a demanding role and supervision and guidance specific to the role helps workers to meet these demands. In addition, regular opportunities for key workers to meet each other are important aspects of learning and support.

Type of key worker

- Designated key workers were found to have some advantages over nondesignated key workers, in terms of contributions to outcomes for families, ease of management and development of team spirit. However, findings suggested that the

potential disadvantages of non-designated key workers could be overcome by provision of training, supervision and peer support. Nevertheless, the appointment of designated key workers should not be ruled out solely on cost grounds. Analysis of costs indicated that estimated average costs per family per year for services with designated key workers were £1,380 to £2,300 and those for services with non-designated key workers were £1,565 to £2,935.

Quality and costs of the service

The higher costs of more intensive contact with families were associated with greater satisfaction with the service and a greater impact on parental quality of life. However, when controlled for other aspects of the service, costs were not directly related to better outcomes for families suggesting that the way key workers provide support may be more important than overall levels of contact.

Evaluating key worker services

Evaluating the outcomes of multi-agency partnerships is notoriously difficult and the lack of evidence on outcomes in this field is testament to such difficulties (El Ansari *et al*., 2001). The many and diverse factors that may contribute to the effectiveness of the process of multi-agency working are not easy to measure, but some assessment of these factors is vital if research is to be able to answer questions about not just whether an intervention works, but how it works. Evaluation needs to explore the mechanisms by which a service produces positive outcomes (or not) and the context (circumstances of the service and of recipients) in which these mechanisms operate to produce these outcomes, or ‘what works for whom and in what circumstances’ (Pawson and Tilley, 1997). The concept of an outcome must also be clarified (Nocon and Qureshi, 1996), distinguishing between 'intermediate outcomes', such as the delivery of a particular service or effects on the knowledge and practice of professionals, 'process outcomes' that is the effects of the way in which the service is delivered on users, and the impact on users of the service, such as changes in well-being – sometimes termed 'distal outcomes' (El Ansari *et al*., 2001). Although intermediate outcomes are important and can help to explain the mechanisms by which the service impacts on users, they are not sufficient measures of effectiveness. In order to assess outcomes, it is important that evaluation obtains the views of the different stakeholders in the services on the extent to which the services meet their desired objectives and the appropriateness of the service to the needs of users (Glendinning, 2002). As well, as exploring outcomes, Glendinning notes that evaluation of multi-agency services should also look at efficiency, that is the relationship between costs and benefits.

Previous research on the needs of families with disabled children and existing studies of local key worker services provide important information to help define outcomes to be measured when comparing models of key worker services. For example, questions about intermediate outcomes are:

- Does the service lead to better coordinated care for disabled children and their families, better access to services, better relationships with services, and better information provision to families?
- Do key workers provide support to families in the areas identified by research as important elements of the service?

Questions about impact on families are:

- Does the service result in fewer unmet needs for parents or children? Does the service impact on family burden and quality of life?

- Does the service impact on levels of social inclusion for children and parents? In order to understand the context in which these outcomes are produced detailed information about the services and the processes which affect them is needed.

It is clear from the above that the evaluation of models of key worker services requires a mixed methods approach, gathering evidence from a variety of sources. Quantitative measures can provide information on some outcomes, but qualitative methods are required to explore some of the processes that may be important in producing such outcomes. A number of authors now advocate such a mixed methods approach to bring new insights in the study of joint working (for example, Popay and Williams 1998; El Ansari *et al*., 2001).

Chapter 4: The Seven Key Worker Services

Skills and knowledge needed by key workers

There was considerable agreement between everyone interviewed about skills, knowledge and personal qualities needed by key workers, i.e.:

- Good communication and listening skills.
- Ability to empathise with families, build rapport and develop relationships of trust with families and other professionals.
- Ability to 'stand back and step outside' one particular discipline. As one interviewee commented key workers should not be 'precious' about their own particular profession.
- Negotiating skills and diplomacy.
- Ability to see the whole family.
- Team working.
- Knowledge of the roles of other agencies, how other agencies work and what is available locally and nationally.
- Ability to find information and to admit that they don't know all the answers.
- Time management skills, ability to plan effectively and be a good organiser.

In addition, more specialized skills were suggested by respondents, i.e.:

- Medical knowledge applicable to children who have specific health needs.
- Having a good understanding of disability issues.

Greater emphasis was placed on 'people skills' than specific knowledge, as it was felt that knowledge could be learnt but these softer skills were harder to acquire. In areas, where regular training was provided this was an important way in which key workers acquired knowledge, and learning from each other also contributed to this. Interestingly, managers in two areas which did not have key worker training noted training was needed for key workers to acquire knowledge necessary for the job.

Constraints and problems of the key workers' role

Key workers were all asked whether they experienced any constraints or problems in their role. A consistent theme among non-designated key workers was having insufficient time to devote to the role. This was linked to a number of factors, some of which varied between areas:

- Not having protected time for the role,
- Uncertainty about how much time they were allowed to spend on the this role and feeling that they needed to justify the time spent on the role to their line managers, and the time demands of the service's paper work.
- Problems of juggling their two different roles, their key worker role and their ordinary professional role. Some non-designated key workers had agreed a certain

amount of time per week that they would spend on the role, but for others key working time was integrated into their caseload and no specific amount of time was agreed. In either case, the realities of key working and the uneven patterns of need of different families at different times meant that flexibility was required: a lot of time might be spent on the role in some weeks, but very little in other weeks. For some workers, this caused problems and they could feel that they were in danger of not doing justice to either their main job or the key worker role.

- Another consistent theme across services was the constraints engendered by gaps in the provision of services in their area and lack of resources, which meant that the needs they identified could not be met.

- Problems in making contact with other professionals, both to pass on information and to obtain information, were common. Time spent trying to contact other non-responsive professionals was a common cause of frustration, and some key workers felt that it was difficult to get other professionals to understand their role and liaise with them, so that important information was not passed on to them and communication seemed to be one-way.

4.8 Multi-agency working

Facilitating multi-agency collaboration
Despite all seven services having multi-agency involvement in steering the service, there were differences between areas in extent to which successful multi-agency working had been established. In all areas, majority of key workers interviewed collaborated with professionals from many different agencies on behalf of families. These agencies included housing, leisure and the Benefits Agency, as well as health, education, social services and other relevant local organisations, such as Sure Start and voluntary agencies.

In four areas, multi-agency working was seen by managers and key workers as operating relatively well, although some barriers were still identified. In the remaining three areas, the picture was more patchy; in one area collaboration at management level appeared to have been established but key workers identified considerable problems at practice levels; in the other two areas problems were apparent at all levels with lack of commitment and active involvement of some of the statutory agencies. A number of themes emerged about factors underlying successful multi-agency collaboration:

- Building on an existing base of good multi-agency working when the service was set up.
- Having some dedicated funding and financial contributions from all three statutory agencies was seen as key to their commitment to the service.
- Management in the different agencies recognising the need to pool resources to improve services, being open to new ideas and prepared to support different ways of working.
- Good communication, keeping all professionals in different agencies informed about the service and its role, and being clear about each agency’s role.
- The role of the service manager was central in facilitating successful multi-agency working at practice and management level. Service managers kept agencies and professionals informed about the service, liaised with them, promoted the service to them, and facilitated key workers’ access to other agencies. They were seen as ‘champions’ of the service and their leadership of the service was important in

establishing its credibility with agencies.

In addition, steering groups played a key part in clarifying each agency's role and facilitating communication with members' own agencies. In one area, the fact that a voluntary agency was the lead, employing the service manager and chairing the steering group, was seen as helpful in promoting multi-agency working and diffusing tensions between agencies. The work of key workers on the ground also facilitated contacts between agencies.

Some key workers described how the service fostered multi-agency collaboration because through information sharing on specific case loads they came to appreciate more about the working contexts of other professionals, including the constraints that they worked under, and 'as time goes on you realise that you're actually working towards the same thing'. This was viewed as breaking down stereotypes and challenging preconceptions:

Sharing information and records between agencies was important in enabling the services to work successfully. Most services had experienced problems around confidentiality and sharing information, but these had been addressed in some areas by setting up systems whereby parents gave permission to share information.

Barriers to successful collaboration

All areas identified barriers to multi-agency working. A number of common barriers had been experienced across areas, whether they had successfully established collaboration or not. These included:

- Lack of funding and resources were key barriers to a successful multi-agency service. In areas experiencing the most difficulties, there was no dedicated multi-agency funding for the service. This was seen as meaning that there was no ownership of the service.
- Even where there was some multi-agency funding for the service, problems could still arise at practice level over which agency should fund resources or equipment needed by families. This was frustrating for key workers when trying to put together appropriate support for families and it was felt that these problems still needed to be sorted out at strategic levels. Inadequate staffing levels and heavy caseloads in services in many of the areas meant that agencies were unable to commit sufficient staff resources to the key worker service.
- Similarly, where funding was committed from the three statutory agencies, inequities in funding and the funding streams being kept separate rather than as pooled budgets were still seen as barriers to good collaboration.
- Although information sharing was established in some areas, 'confidentiality' was still a problem in others.
- Different knowledge, values, language and working practices between different agencies and professionals often impacted on the services. In the more successful examples of multi-agency working, these problems had been overcome over time as the expertise of the key workers was recognised and key workers were careful that other professionals did not feel marginalised or undermined. It was acknowledged that this was an ongoing issue that key workers needed to address, that 'people can be precious about what they do' and sometimes sought to safeguard their own role against perceived encroachment of a key worker. It was important that other professionals were made aware of what the key worker role was, and where this was not the case and communication was poor, there could be duplication of work between the key workers and other professionals.

- Lack of joint working at organisational levels and gaps in communication between practice and management levels also impacted on key workers ability to carry out their role. One key worker described this as the different agencies and professionals working towards the same aims but still travelling on different tracks.
- Where the service itself was experiencing problems in setting up systems or finding sufficient resources, this impacted on relationships with other agencies. Key workers in one area which had a waiting list for the service felt that other professionals did not have faith in the service because of its long response times.
- Different priorities for the different agencies were mentioned as problems in all areas. In particular, it was felt that education was the agency least committed to the key worker services because as a universal service, they placed less priority on disabled children. This issue is explored further in Chapter 7.

Effects of the key worker services on other professionals and agencies
Where multi-agency working was established, in general interviewees perceived the services as having positive effects on the work of other professionals and agencies. They noted that key workers were able to access appropriate support for families and refer to appropriate services, they arranged meetings and took responsibility for contacting people, they facilitated contacts and understanding between professionals, they undertook work on issues that were not within the specific expertise or remit of other professionals, and by being proactive they could anticipate future needs of families and provide information for management so that forward planning was facilitated. In carrying out these tasks, it was felt key workers reduced the workload of other professionals. However, it was also acknowledged that key worker services could produce more work for other agencies by increasing referrals and making families more aware of services and of their entitlements.

However, it was clear from interviews with key workers that not all undertook the roles described above. In some areas where the key worker's role was less clearly defined and where multi-agency working was not yet well established, some key workers did not see collaboration with other agencies as an important part of their role. Thus tasks such as liaison with housing departments and helping families to obtain benefits were seen by a few key workers as out with their role.

Perceptions of advantages and disadvantages of the services
All interviewees were asked about the advantages and disadvantages of their service for parents and children, key workers and other professionals. A number of themes emerged across the services which identified the advantages and disadvantages of key worker services in general. There was a great deal of consistency in these themes and in many ways they echo and summarise many of the themes that have been detailed throughout this chapter. In addition, information about the advantages and disadvantages of particular service models, and the improvements thought to be needed in the different areas, provided further insights into the pros and cons of designated and non-designated key workers and needs for training, support and clarity about roles. In this section, general points will be described first.

Advantages of the key worker services
The role of key worker was seen as having a number of advantages for key workers themselves.

- Key working was seen as an opportunity to get to know children and families well, build good relationships with them and understand their situation.

- Key workers felt that they were really able to ‘make a difference’ for families and so the job was rewarding and job satisfaction was high. As a result of their increased knowledge about children and families, key workers felt that they were better able to communicate with other professionals about the family, and the key worker services themselves provided effective frameworks for information exchange, particularly through care planning meetings and reviews.
- Key workers also appreciated learning new skills and learning about other disciplines. Where it occurred, working as part of a key worker team, and having opportunities for support and learning from other team members, was also highly valued.
- Perceived advantages for parents and children of having a key worker were centred around having one person to contact about any concerns, someone who was in charge of coordinating services and making sure needs were met, and not having to keep telling your story to different professionals. This meant that families were not ‘battling’ for services, there was greater consistency and continuity of care and thus stress was alleviated. In comparison with usual services, key worker services were said to provide better information to families, quicker referral to other services and access to appropriate services and placements, and to reduce misunderstandings and duplication.
- Importance of key worker building a relationship of trust with families and working in partnership with families was emphasised and it was felt that this decreased parents’ feelings of isolation. Key workers also built relationships with children and young people. This was seen as valuable in providing a supportive adult outside the family for some disabled children and young people, and in some cases, the key worker could provide a mediating role between parents and children.
- The key worker’s role in ‘seeing the whole picture’ of the family was also seen as important, enabling key workers to assist in meetings needs of all family members. The care planning processes that were part of the services aimed to involve families as equal partners, and provided a means for families to ‘see a way forward’ and have agreed aims that everyone would work towards. In one service, which provided a time limited input, key workers were said to model strategies and practices for accessing resources which families were then able to adopt themselves, and they were then empowered to take on their own care coordination.
- Advantages of the service for other professionals were also identified. Again these centred around having one point of contact regarding a family, being a source of information and knowing what all agencies were doing with regard to a family. Key workers were seen as ‘lightening the load’ and reducing pressure on other professionals, as illustrated by the comments of this professional who was a member of a steering group.

Disadvantages of the key worker services

Most of the disadvantages mentioned for key workers themselves were specific to certain models of service and these will be dealt with in the next section.

- A more general disadvantage for the service was raised in one area, but could equally have applied to other areas. This was the reliance of the whole service on the service manager. There was concern that if the manager left or the post ceased to be funded, the service would cease to exist.
- It was also acknowledged that key working is a demanding role, key workers were at risk of becoming too emotionally involved and having appropriate support in the role was important.
- Whilst interviewees talked about advantages for families in concrete terms, they

found it harder to identify disadvantages. Those they did mention tended to be expressed as possible disadvantages, rather than ones that they themselves had seen. These potential disadvantages included:

- expectations could be raised that could not be met by the available resources in the area;
- the service could foster dependency among families; and
- there may be problems for families if the key worker was not knowledgeable in all areas of a family's needs.

- In one area there were concerns about the process of choosing a key worker. In this area, parents were asked to choose their key worker from among different professionals at a panel meeting. It was felt that this could put parents 'on the spot' and be daunting for them. In this service, it was also felt that the role of the key worker was unclear to parents, thus increasing problems around choosing a key worker.
- The disadvantages for other professionals were also few, mainly centering round the view that other professionals may feel threatened or undermined by the role of the key worker, and if key workers were identifying unmet need they may be seen as 'hassling' other professionals.

Advantages and disadvantages of different models of services

There was considerable discussion of the advantages and disadvantages of designated and non-designated key workers. Table 4.1 summarises views on this.

Table 4.1 Advantages and disadvantages of different types of key worker

Advantages (Designated key workers):

- Easier to supervise and manage
- More time for key working
- Greater availability for families
- Greater knowledge and awareness of services
- Clearer job specification
- Greater team spirit
- Higher motivation
- Independence of statutory agencies
- Able to advocate for families.

Disadvantages (Designated key workers):

- Hybrid profession
- Possibility of losing skills.

Advantages (Non-designated key workers):

- Variety in roles for the individual worker
- Variety of knowledge and perspectives brought to the scheme by workers from different agencies, so that all could learn from each other
- Key worker knowledge and skills informing everyday work.

Disadvantages (Non-designated key workers):

- Not having protected time for the key worker role
- Conflict of priorities between different roles, and key worker role taking second place
- Not being 'an expert in everything'
- Not using key worker skills all the time
- Uncertainty about the role
- Little contact with other key workers
- Juggling two roles
- Failure to know difference between two roles.

As can be seen from the table, more advantages were identified for designated key workers and more disadvantages for non-designated key workers. However, both models were seen to have strengths and some of the disadvantages identified for non-designated key workers may be overcome by better management of the services. For example, uncertainty about the role can be addressed by having a clear job description, training and supervision in the role. Similarly, having protected time for the role is an issue for line management, but it was also acknowledged that key working is not a role that can easily be accommodated in having a set day or hours per week as families do not have crises to fit in with the key worker's timetable. Time difficulties were particularly problematic for key workers who had heavy caseloads in their everyday jobs and who felt that there was little recognition of the key worker role from their line managers. In this situation, they could easily become demoralised and this was a factor that was thought to have contributed to the decline in the service in Area G.

Interestingly, the disadvantages identified for designated key workers were hypothetical, they were seen as a risk of the role but had not been experienced by the designated workers we interviewed.

Suggested improvements to services

The suggested improvements to services tended to be specific to each service. Improvements said to be needed in some services were already valued features of other services and thus we can begin to identify what were viewed as the important elements of a good key worker service. These features include:

- A clear description of the role of key worker for key workers, families and other professionals.
- Provision of administrative support for the service and for key workers.
- Regular training, supervision and support for key workers.
- A register of information about services for key workers and families.
- Communication between key workers and opportunities to meet and exchange information and experiences.
- Dedicated multi-agency funding.
- A manager who can devote time to supervising the service.
- Frameworks and timescales for assessment and review and explicit guidelines.

In one service, the paperwork devised for the scheme was seen as time-consuming and unwieldy, yet in another service, where key workers had been involved in drawing up forms for paperwork, this was seen as a valuable part of the scheme. In two services, a lack of some of the characteristics described above was identified by some of the key workers we interviewed as impacting on recruitment and retention of non-designated key workers and on the ability and willingness of existing key workers to carry out all aspects of the role. In particular, lack of support for key workers, including training, supervision and administrative support, was thought to be a significant problem.

There were a few improvements that, as yet, none of the services had fully managed to achieve. Non-designated key workers wanted protected time for key working and, in some cases, more negotiation with their line managers about how much time and effort they could spend on their key worker role and reductions in case loads in their main jobs to allow this to happen. Some services recognised the need to involve children and young people in planning the service, but none had done this as yet,

and key workers would have appreciated guidance on consulting with disabled children and young people.

Chapter 8: Interviews with Families

Characteristics of a good key worker

Families reported that the following elements were important in a quality key worker service (Mukherjee *et al.*, 1999):

- Proactive, regular contact initiated by the key worker. This should be at intervals agreed between key worker and family and often may be just a phone call. Families did not want it to be left up to them to contact the key worker. The service should not be just a crisis intervention service.
- Listening to families and developing a supportive open relationship, promoting a sense of trust which allowed family members to be honest and open with their key worker. This takes time to develop and highlights the importance of the personal qualities of the key worker and of continuity of worker. It was facilitated by key workers visiting families at home, so that families were on home ground and felt more in control, and so that key workers got a more holistic view of the child and family and an understanding of the everyday experience of caring for the child.
- A family centred approach, acknowledging and exploring the needs of all family members, not just the disabled child.
- Working across agencies, those agencies that were formally included in the key worker scheme, but also others, such as housing and the Benefits Agency. Key workers needed to know what different agencies can offer and how to go about accessing different agencies. Having named contacts in agencies helped in this. It was also important that this was seen by managers as an integral part of the key worker role.
- A flexible approach, identifying families' strengths and preferred ways of coping, and negotiating with them as to the support and input needed from the key worker and other services. The negotiating model for working with families (Dale, 1996) seems to be central to a good key worker service.
- Working for the family rather than working solely within a certain professional or agency role. If necessary, some families wanted key workers to be able to act as advocates for them.

Chapter 9: Discussion and Conclusions

Key worker services in the UK

The first stage of the research was to find out about the current pattern of multiagency key worker services. Results of a UK-wide survey, carried out at the start of the project in autumn 2002, identified 30 key worker services. The proportion of areas having key worker services was consistent with findings on research with parents of disabled children, which has reported that less than a third of families have a key worker. However, it was encouraging that 50 areas stated that they were planning to develop care coordination schemes in the next year.

The picture of care co-ordination obtained from this survey was one of considerable diversity. However, there was much emerging from the results that can be recognized as good practice. First, the majority of schemes had all three statutory agencies involved in setting up and overseeing the scheme. This indicated a substantial commitment to promote and support multi-agency working. A second encouraging

finding was that, in most cases, parents were involved in setting up and overseeing the schemes. This indicated that the intention to increase user involvement and participation in decision-making was being put into practice (e.g. *The NHS Plan*, Department of Health, 2000; *Shifting the Balance of Power*, Department of Health, 2001). Other encouraging results were that many schemes had open referral, enabling parents and families to refer themselves and their children to services, and that most of the schemes covered all age groups of children.

However, other aspects that have been suggested as good practice were less common. These included involvement of children and young people, joint funding, training for key workers, mechanisms for care planning with the family, and limitations on age range for eligibility. Children and young people were rarely involved in setting up or overseeing the schemes. Disabled children hold and can express views, given the right environment and support (Alderson, 1993), and there is evidence that children's views are different from adults' and they have valuable and useful ideas. However, involving children requires additional resources and skills (Lightfoot and Sloper, 2003) and disabled children are less actively involved in decision making than non-disabled children (Sinclair and Franklin, 2000). The results of the survey suggest that more effort could be expended in ensuring that children and young people's views are heard.

Evident that, although agencies were jointly setting up and overseeing the schemes, joint funding from all three statutory agencies was still rare. Few schemes were using the opportunity to pool budgets given by the 'flexibilities' in section 31 of the Health Act 1999. In addition, short-term funding for many of the schemes is a concern. Only half the key worker schemes were able to provide full information on their expenditure or staffing profile. Some of this information deficit was due to the multi-agency working arrangements that relied on agreements about seconded or 'borrowed' staff rather than financial transfers. It is perhaps more concerning that many schemes were not able to report how much time non-dedicated key workers spent on this role or how many children received key worker support from their service.

Appropriate key worker training is suggested as important for a successful service (Mukherjee *et al*., 1999). The extent of training received by the key workers varied greatly across the sites, and some of the schemes provided no training. Care planning arrangements were also variable. Nine schemes had no initial planning meeting held between the family and the professionals involved in care. Such planning and cooperation is seen as essential in order to avoid duplication and omission of support to children and families and as an important condition for care coordination and multi-agency working (Healey, 1989; Yerbury, 1997).

Understanding and carrying out the key worker role

Training is needed for key workers on the different aspects of the role. Where such training was in place, it was greatly appreciated by key workers and, as shown in the path analyses, was a significant factor in promoting positive outcomes for families. Mukherjee *et al*. (2000) suggested that induction training must take the time to ensure that key workers have a clear understanding of:

a. which tasks they are and are not expected to take on for the family,
b. what areas they are responsible for, and
c. to whom they are responsible.

Moreover, induction training should be followed up with regular ongoing training and supervision. Given the importance of the aspects of key working scores in the analysis of factors related to outcomes, it is clear that the definition of the key worker role and training for the role should include all the aspects encompassed within this measure.

The varied aspects of this role, as defined in Section 9.3 (Different models of key worker services in practice), point to the importance of the skills and access to knowledge of key workers and their personal qualities. Whilst no one person is likely to have all the knowledge needed for the role, training, identification of sources of information and access to other services are important in ensuring that key workers can carry out the role. Parents understood that key workers could not be experts in every field but were happy when key workers were
able to find out information and get back to them. The personal qualities that parents thought were important for key workers included listening and communication skills, tact and diplomacy, approachability, respect for families' expertise, and persistence.

Key working is a demanding role and key workers also appreciated supervision focusing on the role and peer support in the services where this was provided. Supervision and support, along with training, helped key workers to gain knowledge of other services, aspects of disability with which they might not be familiar, and different ways of working from their normal professional role.

A question that is often posed about key working is: 'is it a different role from that already carried out by professionals such as social workers and health visitors?' Although some key workers interviewed thought that key working was no different from what they did in their usual professional practice, these tended to be in services with less successful outcomes. This research found that key working took up extra time and involved extra effort for most key workers. Key workers have a 'hybrid' role that requires a broad range of skills and knowledge. The research showed clearly that it is performed best when it is not an add-on role without time and extra provision set out for it. This goes against the opinion that key working is what professionals already do and is just good practice. Key working is also about joining up meetings, promoting communication between professionals, and being a hub of information for services and agencies that are outside of one's own professional remit. This involves a general knowledge of other agencies and professionals that is uncommon for professionals who work within a specialised role.

Resources for key working

Protected time for key working was an important issue that came out of this research, both in the interviews with staff and families. Protected time is necessary for the key workers to carry out what can be a very involving and time-consuming task, and time is also needed for key workers to take part in training. Most families were aware that the non-designated key workers had many other families on their 'main job' caseload and, in some cases, they felt that this detracted from their ability to be a key worker. Key workers expressed at times that the key worker role ate into what was their working time with the other job, and some felt that as a result they were not doing justice to either role. There needs to be a specified limit of the number of families a key worker can reasonably take on. For non-designated key workers this must take into account their existing caseload in their main professional role. Figures from this study suggest that non-designated key workers could work with about three families. For designated key workers, caseloads were around 30 families. There should be regular checks that the caseload is appropriate.

Time allotted to key working should be generous, and it should be kept in mind that it is impossible to key work at a certain time each week. There are peaks and troughs in demand and a need for flexibility, so the work will be spaced out across the week. The line manager should be aware of and respect this protected time, for instance in the allocation of new cases. There needs to be information to and involvement of line managers in the key worker service. Non-designated key workers experienced problems when line managers did not understand or recognise the needs of the role. In addition to time, key worker services need resources for administrative support, training and a manager who has protected time for managing the service. Some dedicated funding is needed for these resources.

Given the importance of protected time, the findings from the earlier survey are somewhat concerning. The absence of full information on expenditure, staff inputs and caseload in more than half the existing key-working teams means that not only is the managing organisation uncertain about the level of service provision and its cost, but also that the service manager has insufficient information to gauge how much service is going to who or to help key workers to protect their time to undertake key working activities.

Multi-agency working

A key role of steering groups was in ensuring multi-agency involvement in the services. In principle, all groups had involvement from all three statutory agencies, although in practice not all representatives attended the group regularly. Key workers themselves collaborated with professionals from many different agencies, including those outside the service, such as housing, leisure and the Benefits Agency. Many examples were provided, by parents and key workers themselves, of key workers liaising with other agencies and professionals. Multi-agency working appeared to be operating relatively well in four services but was more variable in the other three. Problems relating to confidentiality and sharing information had been addressed in some areas by setting up systems whereby parents gave permission to share information, and multi-agency care planning and review meetings were seen by both parents and staff as a central part of multi-agency working. Parents particularly appreciated these opportunities to get people together and share information, but there was variability between and within services in the role taken by key workers in these meetings. Parents were most appreciative when key workers provided support both in preparation for and at the meeting.

Provision of funding for the service was seen as indicative of multi-agency commitment and managers recognised the need to pool resources to improve services. Despite this, pooled budgets were rarely used, and parents provided a number of examples of disputes and delays arising because of lack of joint funding for services such as equipment.

The facilitators of and barriers to multi-agency working that were identified in our interviews were similar to those described in Chapter One that have been identified in other research (for example, Atkinson *et al*., 2002; Cameron and Lart, 2003; Sloper, 2004). It is clear that further progress is needed in ensuring equal commitment to the key worker services and sharing resources. Service managers played an important part in promoting communication and information sharing and key workers also facilitated contacts between professionals. It is important that these aspects are recognised as part of the roles of service manager and key worker.

In general, differing priorities between agencies were seen as barriers to joint working, and in this respect, as in Townsley *et al.*'s (2004) study, it was felt by some key workers and service managers that education was the agency least committed to the service. It was notable that in all seven areas, the service manager was from a health or social services background and it is possible that they found it easier to communicate with these agencies. Nevertheless, our research with schools showed that on the ground there were many examples of good practice in relations between key workers and schools.

Implications for future research

The study highlights the importance of training and supervision for key workers and provides some information on the training and supervision some of the services provided. More detailed investigation of training needs and programmes and arrangements for supervision would further inform service developments.

A question that is often asked is which professionals should be key workers. A range of professionals undertook the role in the study services and we were not able to ascertain any patterns that might suggest that some professions are more appropriate than others. More detailed work to investigate the experiences and outcomes of key workers from different professional backgrounds would help to answer these questions, but it should be noted that such research should be able to control for the effects of training, supervision, how time is allocated for key working in the service, and type of key worker, as it was these aspects rather than the professional backgrounds of key workers per se that seemed to have greater effects on the way key workers carried out their role.

Although the services in this study were all set up and managed in collaboration between all three statutory agencies, pooled budgets were not being used. With the policy push for more integrated services and greater use of pooled budgets and joint commissioning, research on the ways in which this is implemented and the impact on the services families with disabled children receive is needed. It was also apparent that multi-agency working with other services outside the key worker scheme was often not in place. Another research area is how key workers are perceived by, and assist with the work of, (or generate more work) for other agencies, including Housing, the Benefits Agency, voluntary bodies, and Parent Partnerships.

This research was only able to obtain a view of key worker services at one point in time. Although we asked about the impact of key workers on other the work of other professionals, we were not able to obtain the views of the whole range of other professionals on this, to compare experiences of other professionals for families who did or did not have key workers, and to track this over time. Further research on this would help to answer questions over whether, in the long run, key workers do prevent duplication and save time for other professionals.

The findings from the education dimension of the project, suggest that there is a need for more detailed research on how key workers impact on the way mainstream schools are coping with the inclusion of disabled pupils and how this compares with pupils who do not have key workers.

Better information on the costs of key working services is required as this study indicates a wide variation. Understanding what influences costs – both at the service and the user level – will provide a better evidence base for the development of the

service. Our findings also suggest that more research is needed into the place and impact of key workers within the full array of supports used by families with disabled children. It is likely that the contact costs are only a small part of the total cost of disabled children's care packages but key workers have been shown to be a pivotal service in these families' lives. We cannot tell from this study the extent to which key working supplements, complements or substitutes for other supports, or the extent to which key workers link families into more services, more appropriate services, or into different services. Each of these possibilities may have an impact on the costs of supporting families and their outcomes. With costs per annum of around £1,820, key working may prove to be a cost-effective way of providing support and a comparison of costs and outcomes for families who receive and do not receive a key worker service is required.

Finally, further research is needed on disabled children's experiences of key workers. Such research should include observational methods and more in-depth work to explore children's contacts with their key workers.

Summary of recommendations for policy and practice

Management of the service

Multi-agency commitment to the service is required and this should be reflected in the contribution of funding and resources and in a multi-agency steering group that oversees the service. This group should involve senior managers from each agency. If any members leave the group they should be quickly replaced by an equivalent person from their agency so that momentum and commitment is not lost. As highlighted in both *Together from the Start* (Department of Health/Department for Education and Skills, 2003) and the Children's National Service Framework (Department of Health/Department for Education and Skills, 2004a, 2004b), the involvement of parents in this group helps to focus on the needs of families, but it is important that parents' views are a central part of discussions around the design and ongoing development of the service and that they do not feel that their views are marginalised. Part of the role of the group should be to facilitate information sharing, and to agree ways in which the service will gain families' consent for information relating to them to be shared between professionals and agencies.

At a minimum, funding is required to cover the time of a dedicated service manager and some administrative support. Such funding should be agreed on an ongoing basis. Short term funding can increase the fragility of the services. Information on the full service expenditure and use of dedicated key working time should be held by the service manager to help them use the team's resources in the most appropriate manner.

The service manager's role should include inducting key workers, organising regular training and opportunities for key workers to meet together, ensuring that key workers are provided with supervision specific to their role, organising joint care planning and review meetings, and drawing up information about the service and publicising the service to families, and other agencies and professionals. If nondesignated key workers are employed an important part of the role of the manager and of the steering group members is ensuring that line managers in agencies from which key workers are drawn understand the role of the key worker and are committed to the key worker service. The time commitments of the role should be recognised and agreed between the service and the agencies that provide key workers.

The role of the key worker

A definition of the role of key worker should be drawn up and incorporated in a job description. The service manager should spend time going through this definition so that every key worker understands the role. Information for families should also make clear what is and is not within the key workers' role and similarly, key workers should spend time explaining this to families. Families should have written information about the role to refer back to. Other services in the locality, including schools, should receive information about the key workers' role, and key workers and service managers should be proactive in ensuring that relevant professionals know about, and understand the remit of, the service.

Our findings on the crucial effect on family outcomes of whether key workers carried out the majority of aspects of key working, indicate that the key worker role should include:

- Providing information and advice to families about services and support available, both locally and nationally, and how to access these.
- Providing information specific to the child's condition where needed.
- Coordinating care and working across agencies, including supporting families with regard to care planning and review meetings.
- Improving access to services.
- Identifying and addressing the needs of all family members.
- Speaking on behalf of the family when dealing with services.
- Providing emotional support.
- Providing help and support in a crisis.

In order to carry out this role, key workers need training and supervision, and sufficient time to work with the family and with other agencies. They should be proactive in contacting the family.

Key worker training and supervision

Key workers require induction and ongoing training specific to their role. Interviews with staff and families suggested that this should cover:

- Information about the work of all agencies relevant to disabled children and their families, and if possible the provision of key contacts in these agencies.
- Information about common disabling conditions and about where to find further information.
- Information about relevant legislation.
- Information about sources of financial support for families and eligibility criteria.
- The personal skills needed by key workers – communication, listening and
- negotiating skills; communicating with disabled children; time management.
- Disability awareness and understanding of what life is like for families with
- disabled children.

Key working is a demanding role and supervision and guidance specific to the role helps workers to meet these demands. In addition, regular opportunities for key workers to meet each other are important aspects of learning and support.

Care planning

Multi-agency care planning and review meetings should be part of the service. These provide a valuable means by which actions of different agencies and professionals can be agreed in collaboration with parents and, hopefully, young people. Such meetings are also an important part of information sharing. Key

workers should support families to prepare for and take part in these meetings. Whenever possible, meetings should be combined with other reviews, such as statementing reviews, so that families are not required to attend multiple meetings.

Meeting client's and families' needs

Key worker services cannot meet all needs and they are dependent on the resources and other services available in their local area. However, holistic assessment of needs should be part of the overall multi-agency service and key workers can play a useful role in recording unmet need. Data on unmet need should be collated and inform future service development.

Quality and costs of services

Finally, the study shows that quality and costs are linked. Higher costs – summarising more intensive contact – were associated with greater satisfaction with the service and, although less strongly, with a greater impact on parental quality of life. Higher costs were also associated with providing more aspects of care. However, key workers carrying out more aspects of the role with families was more strongly associated with both satisfaction and quality of life.

References

Alderson, P. (1993) *Children's Consent to Surgery*, Buckingham: Open University Press.

Atkinson, M., Wilkin, A., Stott, A. and Kinder, K. (2001) *Multi-agency Working: An audit of activity*, Slough: NFER.

Atkinson, M., Wilkin, A., Stott, A., Doherty, P. and Kinder, K. (2002) *Multi-Agency Working: A detailed study*, Slough: National Foundation for Educational Research.

Beattie, A. (2000) *Service Coordination*, Birmingham: The Handsel Trust.

Bradford, R. (1993) Promoting inter-agency collaboration in child services, *Child: Care, Health and Development*, 19, 355-67.

Beresford, B. and Oldman, C. (2000) *Making Homes Fit for Children: Working together to promote change in the lives of disabled children*, Bristol: The Policy Press.

Cameron, A., Lart, R., Harrison, L., MacDonald, G. and Smith, R. (2000) *Factors Promoting and Obstacles Hindering Joint Working: A systematic review*, Bristol: School for Policy Studies, University of Bristol.

Coles, B., England, J. and Rugg, J. (2000) Spaced out? Young people on social housing estates: social exclusion and multi-agency working, *Journal of Youth Studies*, 3, 21-33.

Dale, N. (1996) *Working with Families of Children with Special Needs: Partnership and practice*, London: Routledge.

Dobson, B. and Middleton, S. (1998) *Paying to Care: The cost of childhood disability*, York: York Publishing Services.

Dyson, A., Lin, M. and Millward, A. (1998) *Effective Communication between Schools, LEAs and Health and Social Services in the Field of Special Educational Needs*, Research Report RR60, London: DEE.

El Ansari, W., Phillips, C.J. and Hammick, M. (2001) Collaboration and partnerships: developing the evidence base, *Health and Social Care in the Community*, 9, 215-27.

Glendinning, C. (2002) Partnerships between health and social services: developing a framework for evaluation, *Policy and Politics*, 30, 115-27.

Healey, A. (1989) The individual, the family and the community: co-operation is the future, *Developmental Medicine and Child Neurology*, 31, 567-69.

Lightfoot, J. and Sloper, P. (2003) Having a say in health: involving young people with a chronic illness or physical disability in local health services development, *Children and Society*, 17, 277-90.

Mukherjee, S., Beresford, B. and Sloper, P. (1999) *Unlocking Key Working*, Bristol: Policy Press.

Mukherjee, S., Sloper, P., Beresford, B. and Lunt, P. (2000) *A Resource Pack: Developing a key worker service for families with a disabled child*, York: Social Policy Research Unit, University of York.

Nocon, A. and Qureshi, H. (1996) *Outcomes of Community Care for Users and Carers*, Buckingham: Open University Press.

Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*, London: Sage.

Popay, J. and Williams, G. (1998) Partnerships in health: beyond the rhetoric, *Journal of Epidemiology and Community Health*, 52, 410-11.

Sinclair, R. and Franklin, A. (2000) *Young People's Participation. Quality Protects Research Briefing No.3*, London: Department of Health.

Sloper, P. (2004) Facilitators and barriers for coordinated multi-agency services, *Child, Care, Health and Development*, 30, 571-80.

Sloper, P., Mukherjee, S., Beresford, B., Lightfoot, J. and Norris, P. (1999) *Real Change not Rhetoric: Putting research into practice in multi-agency services*, Bristol: Policy Press.

Tait, T. and Dejnega, S. (2001) *Coordinating Children's Services*, Leicester: Mary Seacole Research Centre, De Montfort University.

Townsley, R., Abbott, D. and Watson, D. (2004) *Making a Difference? Exploring the impact of multi-agency working on disabled children with complex health care needs, their families and the professionals who support them*, Bristol: The Policy Press.

Watson, D., Townsley, R., Abbott, D. and Latham, P. (2002b) *Working Together? Multi-agency working in services to disabled children with complex health care needs*

and their families - a literature review, Birmingham: The Handsel Trust.

Webb, R. and Vulliamy, G. (2001) Joining up the solutions: the rhetoric and practice of inter-agency cooperation, *Children and Society*, 15, 315-32.

Yerbury, M. (1997) Issues in multidisciplinary teamwork for children with disabilities, *Child: Care, Health and Development*, 23, 77-86.