Evaluation of the Pilot Cocaine Women's Health Project

September 2006

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1. Women's Health Pilot Cocaine Project

1.1 Introduction

The Department of Community, Rural and Gaeltacht Affairs requested the National Drug Strategy Team (NDST) to put forward proposals in relation to the tackling of cocaine misuse in Ireland. In response, the NDST established a cocaine subgroup to recommend pilot measures and report back to the Team. Recommendations were made in the areas of Training, Education and Treatment.

A Peer Support Women's Health Project was chosen by the subgroup to be the subject of one of the pilot treatment initiatives. The pilot stemmed from a proposal previously developed within the Women's Health Project Team within the East Coast Area Health Board, which proposed using peer support as a model to support women using cocaine.

The target group in this pilot comprised women with problematic cocaine use that were working in the sex industry.

1.2 The Purpose of the Evaluation

The objectives of the evaluation were to analyse in a systematic manner the achievements of the projects and report the findings and the lessons learned, both positive and negative, in order that they can be fully understood and integrated into long term service plans.

The evaluation was to examine the structures, effectiveness, efficiency and value for money components of the projects taking into account the use of the Maudsley Addiction Profiling System (MAPS) in the treatment projects.

1.3 The Project Evaluation Process

Goodbody Economic Consultants (GEC) were appointed external evaluators to the pilot cocaine projects. The external evaluation of the Women's Health Project (WHP) was commenced in October 2005. The WHP also planned to commence its own internal project evaluation at this time. However, at the initial stages of the evaluation process an issue arose as to whether Ethics Committee approval was necessary to proceed with the evaluations. This issue was resolved in December 2005 when it was concluded that Ethics Committee approval was not required. Consequently the evaluations were resumed at this point.

As part of their evaluation GEC met with the project management team and project facilitator in the first half of 2006. The project's own internal evaluation was completed in May 2006. It is currently under review by the project's management committee. Pending the finalisation of the project's internal evaluation, detailed information regarding the outcome of the end-of-project interviews with participants were not made available to GEC. The unavailability of this information has restricted the extent to which GEC have been able to determine the effectiveness, efficiency and value for money components of the Women's Health Project.

1.4 Project Description

The Women's Health project represented a non-scientific, non-evidence based intervention that would examine the effectiveness of 'peer support' as a model to access sex workers using cocaine to influence, educate and ultimately promote a greater awareness among them of the dangers of cocaine abuse. One of the main tenets of the project involved engaging participants in a range of alternative therapies. During the course of the project the project participants would also receive information on health issues including cocaine and its use and sexual health issues. Initially it was intended that the project participants would become peer-workers who would pass on their learning to other women in a similar situation to themselves.

The pilot aimed to decrease drug usage among the women participating in the project, particularly cocaine use and provide support to those who wished to address their cocaine use via alternative therapies and information services. It was intended that the project would be evaluated internally with a view to informing the future delivery of appropriate responses to the target group.

Two issues arose in relation to implementing the project as outlined above. Firstly, owing to the inherent short-term nature of the pilot project and the chaotic lifestyles of the women participants, the question was raised as to whether the peer-workers could be educated to a standard to safely pass on their learning to other women in a similar situation to themselves. Secondly, participation in the project was based on an assumption that the Women's Health Project could successfully identify and recruit women from the target group into the project. After a number of attempts this assumption proved incorrect. It was recognised that the target group's trust would have to be acquired if the Women's Health Project was to successfully engage participants into the project. It was considered that this could only be achieved by involving a person in the project from a drug user' forum who would have responsibility for communicating with the target group and encouraging their participation in the project.

Consequently, it was decided to change the orientation of the project from one of 'peer support' where project participants would assume a role in educating and advising other women in a similar situation to themselves, to one where women participants would bring 'peers'[1] into the project where they too would be afforded an opportunity to participate in alternative therapies and the information sessions. It was also decided to recruit a project facilitator with experience in the area of outreach work and drug user's forums that would have responsibility for engaging and recruiting participants into the project.

1.5 Project Activity

As a first step in the project's development a management committee was formed comprising representatives of the Health Service Executive, the Women's Health Project, the Local Drug Task Force Initiative, Chrysalis, the Ana Liffey project, UISCE, Dublin Aids Alliance and RUANDA.

The management committee tendered for the services of a project facilitator on a contract basis. Prior to accepting the position, the project facilitator made initial contact with a number of women cocaine users working in the sex industry to create awareness and obtain feedback in terms of interest in the proposed project. The feedback received was positive. Having been appointed to the position, the project facilitator subsequently reestablished contact with the women and invited their participation in the project. As well as extensive outreach work on the streets, prospective participants were informed about the project through the facilitator's own contacts, through outreach work in the facilitator's place of employment 'UISCE', as well as through making contact with known drug dealers.

The project facilitator's role as advertised by the management committee was to involve identifying, engaging and recruiting the target group into the project; providing the participants with accurate information in areas such as healthcare, harm reduction, sexual health and working in a safe environment; organising information workshops; arranging childcare as necessary; organising alternative therapies; acting as a support to the group on an on-going basis and evaluating the project's outcome upon its completion.

The pilot project commenced service provision in July 2005, operating two evenings weekly, one evening from Chrysalis's premises on Benburb Street and one evening from the Women's Health Project on Baggot Street. The project was completed in early October 2005. At project meetings complementary therapies were implemented to the participants by staff from both Chrysalis and Merchants Quay who had experience of providing complementary therapies to drug users. The therapies provided include Acupuncture, Indian Head Massage, Reiki,

[1] For the purposes of clarity the women initially brought into the project by the project facilitator's contacts/outreach work/the WHP are referred to as the 'women participants', while the women brought into the project by the women participants themselves are referred to as 'peers'.

Shiatsu, Stress Balls as well as back, head and shoulder massages. After week three, peers were welcomed to attend the project meetings.

From week five, all project participants were offered the opportunity to attend information sessions offered by the project facilitator and/or guest speakers from various organisations and agencies working in a related field. Guest speakers including representatives the Women's Health Project, the Local Drug Task Forces and pharmacy liaison officers provided information to the women participants on topics including:

- Harm Reduction;
- Working in a Safer Environment;
- Sexual Health and General Health;
- Hepatitis C
- Harm Reduction and the Effects of Cocaine on the Body; and
- Effects of Acupuncture and other Holistic Treatments on Cocaine Use.

The women participants were remunerated for their attendance at the complementary therapies and information sessions. The remuneration rates were €30 for participation in the complementary therapies and €20 for attendance at the information sessions. The women participants also received a once-off payment of €30 when they brought a peer into the project[2]. The peers themselves received €30 for their participation in the complementary therapies; they were not remunerated for their participation in the information sessions.

While the project had originally envisaged organising childcare services based on the identified need of the women participants, it was found that the participants did not require childcare services. A number of reasons were highlighted as having contributed to the lack of demand for childcare services. These include the fact that a number of the women had children who were in care while others resided with or had arrangements with parents or relatives who looked after their children on an ongoing basis.

As the project progressed, the extent of the women participants' needs became more apparent. Demands were placed on the project facilitator in terms of assisting the participants to source basic services including housing, healthcare as well as counselling and psychiatric services. As a result, much of the facilitator's time became tied up in linking the women to appropriate services including St Vincent De Paul, drug projects and healthcare services.

[2] Only one payment of €30 was permitted per project participant for bringing a peer into the project.

1.6 Project Inputs

In total €47,000 was allocated to the Women's Health pilot project as part of the Pilot Cocaine Project initiative. At July 2006 approximately €33,000 had been expended by the project. The project expenditure included €21,800 payable to the project facilitator and €10,400 attributed to the guest speakers and the complementary therapists. Approximately €870 was expended on administration and miscellaneous expenses.

The project operated under the direction of a management committee comprising seven members[3], a project facilitator working 20 hours weekly on a contract basis and sessional staff providing the complementary therapies and information sessions. In addition, a staff member from the Chrysalis Project worked in a voluntary capacity to link the women participants into appropriate services. Finally, an external person to the project was contracted to assist the project facilitator in the preparation of the end of project evaluation.

1.7 Project Participants

In total 22 women were contacted by the Women's Health Project. Seven participants were contacted via the project's outreach work. Seven participants were made aware of the project through their contact with the Women's Health Project. The remaining women were 'peers' contacted by the women participants themselves. Of the 22 women who had contact with the project, 18 attended the project on at least one occasion. These included 11 women participants and 7 peers.

During the course of the project the project facilitator became aware of the drug taking habits, health and family status of a number of the project participants. This information is presented in Tables 1, 2 and 3. Among the ten participants listed, eight were in receipt of methadone treatment; nine were taking cocaine while seven were taking various tablets. Eight of the ten participants were receiving some form of treatment for their drug usage. See Table 1.

[3] There were eight members of the management committee at the initial stages of the project's development, however one member discontinued their participation in the committee.

Table 1: Drug taking habits and Treatment received by Project Participants

Participant	Methadone	Tablets	Cocaine	Heroin	Alcohol	Treatment
1			Occasional user			No
2		Yes		Yes	Yes	No
3	Yes	Yes		Yes		Bus
4	Yes	Yes	Yes	Yes		Bus
5	Yes	Yes	Yes	Yes	Yes	Bus
6	Yes	Yes	Yes			Clinic
7	Yes		Yes			Clinic
8	Yes		Yes			GP
9	Yes	Yes	Yes			Clinic
10	Yes	Yes	Yes			Clinic

Source: Women's' Health Project

As outlined in Table 2, three participants were described as in very poor or poor health, in all cases suffering from HIV. Two women were recorded as having mental health issues. One participant had asthma and Hepatitis C and another had HIV. Among the ten participants whose health status was recorded three were considered in good health.

Table 2: Health Status and Supports Received by Project Participants

Participant	Health	Support(s)
1	Good	No
2	Poor (HIV, Hep)	Merchants Quay Ireland
3	Mental Health Issues	Psychiatric assessment
4	Good	Chrysalis
5	Asthma, Hep C	Chrysalis
6	Mental Health Issues	No
7	Very poor (HIV)	DAA & Chrysalis
8	Good	Project facilitator
9	Very poor (HIV)	Chrysalis
10	Low energy, HIV	No

Source: Women's Health Project

Among the ten participants, four were living in hostel accommodation and one was homeless. Five participants had no or very little contact with their families.

Table 3: Home and Family Situation of the Project Participants

Participant	Accommodation	Family Contact
1	Hostel	Unknown
2	Homeless	Very little contact
3	Private	Banished
4	Hostel	Unsettled
5	Private	Banished
6	Hostel	Banished
7	Private	Regular contact
8	Private	Regular contact
9	Hostel	Scattered
10	Local Authority	Regular contact

Source: Women's Health Project

1.8 Project Outputs

Between July and October 2005 18 participants attended the project on at least one occasion including 11 women participants and 7 peers. Among the 18 participants, 10 attended between 6 and 14 project evenings, 8 attended 4 or fewer project evenings.

Three general trends were noted in terms of attendance at the Women's Health Project. Firstly, attendance at Chrysalis project evenings exceeded that of the Women's Health Project on Baggot Street. A number of factors are thought to have contributed to this phenomen including the women's familiarity with the Chrysalis project as well as its centrality and ease of access. The second trend related to attendance at complementary therapies exceeding attendance at the information sessions. This is thought to have stemmed from the higher level of remuneration payable to the participants for their attendance at the complementary therapies (€30) relative to information sessions (€20) and the lack of remuneration payable to the peers for their attendance at the information sessions. Finally, attendance was lower among the women 'peers'. This is thought to be related to the higher level of remuneration payable to the women participants for attendance at the project evenings (€50) relative to their peers (€30).

In addition to complementary therapies and information sessions other supports were also provided to the women participants. The women were invited to avail of needle exchange services at the project meetings. Many of the women availed of this service. Health screening services were also made available at project meetings. Two women availed of this service. Three women were linked in with the Saint Vincent De Paul due to their impoverished living conditions. Four women were supported in efforts to obtain hostel accommodation, three of which were successful. Eight women were referred to the Chrysalis project for counseling/support and continued to attend during and after the project ended. Hospital visits were made to one participant who found themselves in intensive care. Also, the project facilitator provided one-to-one weekly sessions to four project participants; two of which continued to avail of this service after the project had ceased.

The project was completed in October 2005. In November 2006 a graduation evening was organised to celebrate the women's participation in the Women's Health Project. As part of the graduation evening the Director of the National Drug Strategy Team presented participants with certificates for their completion of the Women's Health Project.[4] Five project participants attended the graduation evening and received certificates[5].

As part of the project's internal evaluation process it was decided to implement an end of project questionnaire which sought information surrounding the women's reasons for participating in the project; how useful they considered the project to be; their cocaine usage both pre and post participation in the project; the effects of the alternative therapies on their cocaine usage, as well as their views on the education sessions provided. Prior to its implementation the issue arose as to whether Ethics Committee approval was necessary before a questionnaire could be conducted. This issue was resolved in December 2005 when it was concluded that Ethics Committee approval was not required. Owing to the delay engendered by the Ethical Approval issue the project had lost contact with a number of the women participants who as a result were not administered the questionnaire. In total six women were sent and responded to the questionnaire. Pending the finalisation of the project's own internal evaluation report the information collated as part of the questionnaire process was not made available to Goodbodies.

[4] Women who joined the project midway through, but who maintained regular attendance to the project's completion were considered to have completed the project and were presented with certificates.

[5] Other women who completed the project but who did not attend the graduation evening were also provided with a certificate at a later stage.

1.8 Project Learning

A number of areas were identified where lessons were learnt by both the project management committee and the project facilitator in the implementation of the Women's Health Pilot Cocaine Project.

The initial key area of learning related to the difficulties involved in implementing a 'peer support' project where peer-workers would impart acquired information to other women in a similar position to themselves. The first difficulty related to the short timeframe over which the pilot project was scheduled to operate - approximately a six-month period. Secondly, the target group's chaotic lifestyle meant that consistent participation levels in the project could not be guaranteed. Both of these issues lead to questions being raised as to whether the women participants could be educated to a standard where they could successfully pass on correct information to other women in a similar situation to themselves. As a result, the project orientation was changed from peer support to a programme where the women participants would bring women 'peers' in a similar situation to themselves into the project where they would be given the opportunity to avail of complementary therapies and information sessions.

A second key area of learning related to the need to adopt a holistic approach to working with a target group comprising women cocaine users working in the sex industry. Owing to the chaotic nature of their lifestyle, the project participants' needs were as vast as they were extensive, and ranged from housing and general healthcare services to counselling and psychiatric services. It was recognised that providing a comprehensive response to the needs of the project participants was not possible within the resources available to the pilot project.

In terms of the services provided to the project participants, the complementary therapy sessions were more popular among the project participants relative to the information sessions. The higher level of remuneration associated with participation in the complementary therapies was perhaps a contributory factor. The women 'peers' brought into the project by the women participants themselves were more likely to drop out of the project. One suggested contributory factor was the lack of remuneration payable to the women peers for participation in the information sessions.

Another area of learning related to the nature of the complementary therapies used as part of the project. Acupuncture was not popular among the participants. Owing to the use of needles many women were reluctant to participate in acupuncture therapies. Indian Head Message, Reiki as well as the back and shoulder massages were popular therapies with the participants. It was also noted however that some participants were not receptive to therapies where they were required to remove items of their clothing.

Finally, the need for one project driver to lead the development of a pilot project such as the Women's Health Project was also highlighted as an area of learning. According to the management committee, the lack of one lead agency to spearhead the development of the project lead to delays in decision-making that slowed down the project's development.

1.9 Difficulties Encountered

A number of difficulties were encountered by the management committee and the project facilitator in the setting up and delivery of the Women's Health pilot cocaine project. These difficulties include:

- The chaotic lifestyles of the project participants: All of the women participants were drug users. Nearly all were taking cocaine; many were chronic cocaine users. A number of the women were heavily dependent on tablets including benzodiazepines. In addition, many were in receipt of methadone maintenance. As well as depending on drugs, a number of the women participants were in abusive relationships. As a result, the women had a variety of needs, which had to be dealt with alongside making progress in terms of their cocaine usage.

- The lack of resources available to the project to deal with the issues facing the participants in a holistic manner. The project was a pilot project with limited resources in terms of time, staffing and budgetary resources. It was, as a result, not possible to take on the extensive range of issues and problems facing the target group in a comprehensive manner.

- The lack of an authoritative agency lead figure to lead the project: Managed by a management committee consisting of representatives from a number of voluntary and statutory organisations/agencies, the project lacked a single authoritative figure that would speed up the decision making process within the project.

- The level of bureaucracy faced by the management committee in setting up the project: The project was created by bringing representatives from various voluntary and statutory organisations together to form a management committee to implement a peer-support project working with women cocaine users working in prostitution. As the project got off the ground, a number of administrative issues arose that had to be overcome before the project could progress. These issues included the employing of staff i.e. without a lead agency who would assume the role of employment body; the administration of the project's petty cash system and the souring of premises from which the project could operate.

1.10 Summary and Conclusions

Structure

A number of issues were raised in terms of the structure of the Women's Health Project. These were as follows:

- Lead by a management committee comprising representatives from a variety of agencies, the project lacked one project driver to lead its development;

- Formed via the bringing together of representatives from a number of agencies, the project had to deal with a number of administrative issues including staffing, financial administration and sourcing premises which slowed down the project's development in its early stages;

- The initial difficulties experienced in engaging with the target group lead to the decision to recruit a project facilitator with experience in the area of outreach work and drug user forums who had responsibility for engaging and recruiting participants into the project;

- The short-term nature of the pilot and the chaotic nature of the participant's lifestyles meant the project's orientation was changed from one of peer support, where project participants would assume a role in educating and advising other women in a similar situation to themselves, to one where the women participants would bring other women 'peers' into the project where they also would be afforded the opportunity to participate in complementary therapies and the information sessions; and

Effectiveness

Notwithstanding the extensive efforts of the project management committee and the project facilitator to engage with the target group, bring them into the project on a regular basis and assist them in working through their cocaine dependency, the project did encounter a number of difficulties including a lack of interest among some of the participants in a number of the information sessions as well as a lack of acceptance among a number of the participants in some of the complementary therapies, notably acupuncture and body massages. In addition, owing to the chaotic nature of the participants' lifestyles, it did not prove possible to address the extensive needs of the project participants during the short-time frame and within the resources available to the pilot project.

Based on the information available it is concluded that a more holistic approach addressing the wide-ranging extensive needs of the participants would be necessary as part of any future initiative targeting cocaine users working in the sex industry.

Efficiency and Value for Money

The facilitator of the Women's Health Project with the assistance of an external agent had responsibility for conducting an internal evaluation of the project. Completed in May 2006, the internal evaluation report is currently under review by the project's management committee. Information regarding the results of the project client interviews which are detailed in the internal evaluation were not made available to GEC pending the finalisation of the project's internal evaluation. Owing to the absence of this information it is not possible to determine if value for money was achieved in the delivery of the project.

However, in light of the information made available to the Consultants, it is considered that a more holistic approach to dealing with the varying and extensive issues faced by the target group would render greater value for money.