



T A B O R

G R O U P



An Evaluation of Tabor Group

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EXECUTIVE SUMMARY

Tabor Group is a major provider of residential and community based addiction treatments in Ireland. The model employed is the Minnesota Model also known as the Abstinence Model. The group is comprised of Tabor Lodge (Primary Treatment Centre), Fellowship House (Secondary Treatment Centre for males), Renewal (Secondary Treatment Centre for females) and extended supported accommodation in the community for both males and females. The Group provides a range of treatments, care, support and rehabilitation for those in treatment as well as structured support for their families. In 2017, Tabor Lodge admitted 213 clients to its residential treatment programme while also providing support to family members.

Tabor Group, in partnership with the HSE, commissioned this external evaluation with declared terms of reference and objectives as follows:

- To assess the effects of Tabor treatment programmes(s) across Tabor Group.
- To offer independent examination of the efficacy of the programme(s) as well as the ‘goodness of fit’ of the treatment model.

The genesis of the evaluation also stems from the Group’s Strategic Plan, which calls for an exploration of “the options to have greater flexibility in the duration of the primary residential treatment programme”.

Tabor Group is to be commended for opening its service to external scrutiny and evaluation and is reflective of an organisation focused on quality assured services.

The methodology employed in this report was designed to elicit the views of a wide range of staff, clients and external stakeholders. It was inclusive in nature. Because of the varying backgrounds of the respondents there are differing, sometimes contradictory, views expressed. This is not unusual in evaluation reports of this nature.

Alcohol is the highest recorded substance of abuse across all service locations in the Tabor Group. Ecstasy, cannabis and cocaine were ranked next highest reported substances of abuse with clients attending Fellowship House. With females attending Renewal the highest reported substances of abuse after alcohol were cannabis and cocaine.

Clients spoke of both positive and negative experiences while in treatment. For the most part clients expressed satisfaction with their engagement with the services.

Clients expressed mixed feelings about the model of treatment. For the majority of clients surveyed (7 of 11 clients) the 28 day treatment programme was seen as not long enough. Clients acknowledged that addiction counseling is by nature challenging, but at one location, some clients felt it strayed into a confrontational process, which for them was not conducive to effective outcomes.

Clients expressed a preference for a seamless transition from primary to secondary treatment within the Tabor Group.

Family members placed great value on the support services they received from Tabor Group and considered the services to be comprehensive.

Staff believed that Tabor Group Services had a very good reputation. For the most part, staff valued the support that they received from management, but there was a sense that administration was burdensome and an intrusion on clinical time.

Some staff felt that the wider organisation undervalued them.

There was a sense amongst some staff and clients that Tabor Group was a collective of three separate services rather than a cohesive group.

There was recognition that the work of the company to establish the brand had achieved some success, but several structural and cultural shifts would have to occur before the services would be seen to be cohesive and unified.

The benefits of recent developments from the case-management framework was highly valued by referral agents.

This external evaluation report has identified certain issues, which Tabor Group should address and includes a range of recommendations to assist the service in this regard and specifically in terms of:

- Strategic management and governance issues
- Staffing issues
- Programme issues

RESEARCH TEAM

Dr Jo-Hanna Ivers works at the Department of Public Health & Primary Care at the Institute of Population Health, Trinity College Dublin. Jo-Hanna has worked as a researcher in the Department of Public Health & Primary Care as part of a broader addiction team since 2009. During this time she has completed some large-scale addiction studies including the evaluation of the National Drug Rehabilitation Framework. Jo-Hanna has specific training and extensive experience in a wide range of research methodologies including qualitative, quantitative, neuroimaging process, behavioural intervention and outcome evaluation. She has published in a number of high-impact international peer-reviewed journals and has extensive experience of addiction treatment. Prior to research, Jo-Hanna worked in frontline addiction services.

Professor Joe Barry, Chair of Population Health Medicine at the Department of Public Health & Primary Care at the Institute of Population Health, Trinity College Dublin, has established a drug research group to examine the impact of substance misuse and addiction on population health. His research expertise in this field embraces a wide range of methodologies relevant to the proposal. These include prevalence studies, behavioural and attitude studies, cross-sectional surveys, intervention studies, cohort studies and health outcome studies, including mortality and survival analysis, in addition to policy analysis. He is widely published in international peer-reviewed journals and has extensive experience of the public system and public policy.

ACKNOWLEDGEMENTS

We would like to extend a sincere thank you to all of the service users, staff, board members and referral agents who participated in this research. Participating in research can be demanding, especially when trying to complete a treatment programme and we greatly appreciate the time and effort invested by everyone involved. We would also like to thank the staff of the wider addiction services in Cork for assisting with the recruitment of participants. We extend our gratitude to Mr. David Lane for his input to the proposal. A heartfelt thank you is extended to all members of the research advisory group for their support and feedback throughout the study.

Research Advisory Group (RAG) Members:

The RAG was made up of the research team and representatives from both funding agencies. The RAG was formed at the outset and remained in place until the final report was agreed. The group consisted of:

- Professor Joe Barry: Department of Public Health & Primary Care, Institute of Population Health, School of Medicine, Trinity College Dublin
- Dr Eoin Coughlan: HSE Drug and Alcohol Services, Cork
- Mr Denis Cronin: Board Member Tabor Group Cork (replaced Aileen O’Neill)
- Mr Mick Devine: Tabor Group, Cork
- Mr Joe Kirby: Cork Local Drug and Alcohol Services, Addiction Services, Health Service Executive Cork
- Dr Jo-Hanna Ivers: Department of Public Health & Primary Care, Institute of Population Health, School of Medicine, Trinity College Dublin
- Ms Aileen O’Neill: Tabor Group, Cork (until May 2018)

RATIONALE FOR CURRENT REPORT

In the main, scientific research and programme evaluation have not played a major role in influencing the development of addiction treatment services nationally¹ or internationally². The consequences of this are large disparities in the development, management and monitoring of national treatment systems.

“Evaluation is an attitude of continually questioning and gaining information.”

“With only scarce resources for treatment, duplication and inefficiency in the delivery of services cannot be tolerated.” (WHO, 2000)³.

One of the major barriers to undertaking internal programme evaluation is the belief that it is complicated research. While this is not necessarily the case, evaluation can be challenging. It also involves the routine questioning of current practice even if the feedback may be less positive than anticipated. A healthy culture of evaluation is one where feedback is regularly plotted into the structure of the treatment service or system^{2, 4}. While there may be several obstacles when evaluating addiction treatment services these obstacles can be overcome with vigilant planning and commitment to the development of evidence-based practice.

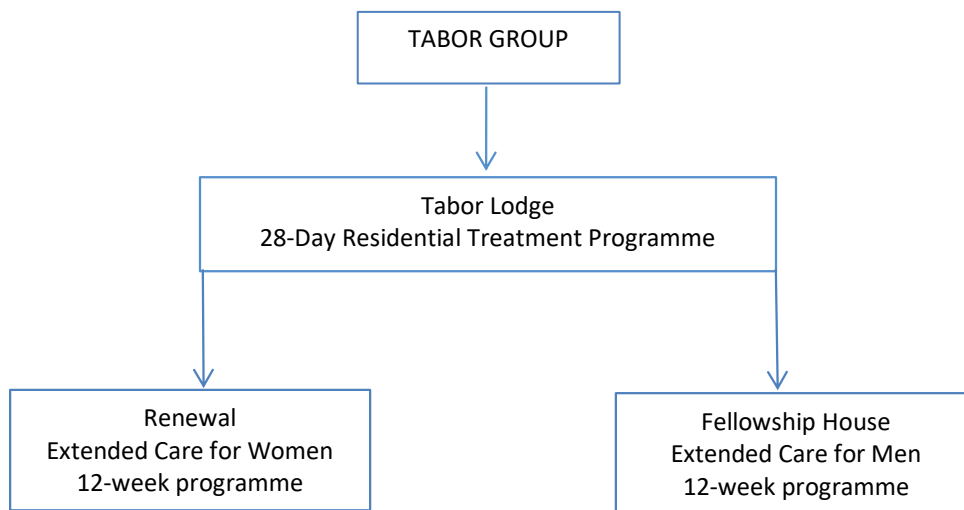
Generally, treatment providers rely on their professional and personal experiences to determine whether or not a particular treatment is effective and fit for purpose i.e. reaching its desired goals⁵. However, owing to the complex nature of treatment programmes and the increasing number of clients entering treatment, the evaluation of such programmes is a necessity in order to ensure that existing resources are well distributed and services are of the highest quality.

Understanding the differing experiences of service users regarding their treatment, offers the best prospects for improving our understanding of their health needs and the opportunities before us to better meet these needs. The proposed research aims to achieve this by evaluating the treatment programmes across Tabor Group. To comprehensively understand this, we included service users, their families, service providers and referral agents. Evaluation is a systematic method for reviewing the experiences of a population, leading to agreed priorities and recommendations regarding resource reallocation that will improve treatment services.

Following the development of their Strategic Plan (2016), Tabor Group decided to commission an independent evaluation of their treatment services. In May 2017, they approached the research team at Trinity College Dublin to undertake the research and in September of 2017 they secured funding from the HSE Drug and Alcohol Services Cork to commence the evaluation.

BACKGROUND

Tabor Group is a major provider of residential treatment in Ireland. The group is comprised of Tabor Lodge, Fellowship House and Renewal, providing a range of treatments, care, support and rehabilitation for people with addictions as well as their families (figure 1 below).



Tabor Group was originally founded as a single residential treatment facility (Tabor Lodge), in 1989 by the Sisters of Mercy to provide treatment for people with an addiction to alcohol. Since then, the company has expanded to include two additional residential treatment centres. The purpose of this was to provide independent accommodation, which delivers a continuum of care from primary treatment where an individual has recently detoxified, to extended care through to independent living. In addition to treatment of addiction Tabor Group also provides services and supports to family members living with addiction. The family services were developed in response to the recognition of the impact of addiction on the family unit. Family counselling services and support groups are delivered both at Tabor Lodge and also in various venues across Cork city.

In 1999, Tabor extended its treatment programme to Renewal to support women who have left their primary treatment and are in the early stages of recovery and need supported accommodation with further treatment. Similarly, in 2002, the Board of Directors further extended the treatment programme to include Fellowship House in response to a need for a residential supportive environment for men in the early stages of recovery. Today the treatment services are collectively Tabor Group. Underlining each of the treatment services across Tabor Group is the core treatment model. Tabor Group treatment model is based on the Hazelden Minnesota Model.

The Minnesota Model, also known as the abstinence model, of addiction treatment, was created in the 1950s by a psychologist and a psychiatrist, neither of whom had prior experience treating addicts or alcoholics ⁶. The model was first adapted to a small non-profit organisation called the Hazelden Foundation, which was initially in the US and later developed globally. The key component of this approach to addiction treatment is the combination of professionally trained clinical staff with peer-led (recovering) staff. The treatment programme is based on the principles of Alcoholics Anonymous (AA). The programme is extremely comprehensive ⁶. There is an individual treatment plan, which includes active family participation, partaking in Alcoholics Anonymous, both during and after treatment. Moreover, clients and families undertake lectures and seminars on addiction ⁶ that aim at educating them around a diseased model of addiction.

Although the Minnesota Model of treatment for alcohol and drug addiction is a standard treatment approach, there are few published reports of its effectiveness⁷. Stinchfield and colleagues (1998) conducted a study that included 1,083 clients admitted to Hazelden for treatment of a psychoactive substance-use disorder between 1989 and 1991. The outcome study was a single group pre and post-intervention design. Data collection occurred at

admission and clients were retested at 1-month, 6-months, and 12-months post-treatment. At 1-year follow-up, 53% reported that they remained abstinent during the year following treatment and an additional 35% had reduced their alcohol and drug use⁷

In an earlier study Keso et al. (1990) conducted the first randomised clinical trial on the Hazelden model⁸. One hundred alcoholics were randomised to either Hazelden-type treatment (N= 74) or to traditional-type treatment (N= 67). The treatment groups were very comparable. Two-week follow-ups were in place for up to one year⁸. The Hazelden-type treatment was more involving, supportive, encouraging to spontaneity and oriented to personal problems than at the traditional-type institute. In accordance, the treatment drop-out rate was 7.9% at the Hazelden-type institute and 25.9% at the traditional-type institute (p less than 0.02). The participation in outpatient treatment was significantly better after the Hazelden-type treatment. The authors found the proportion of participants abstinent was higher in Hazelden-type group during the last four months follow-up (26.3% compared to 9.8%, p = 0.05). Moreover, 14% of the Hazelden-type participants and 1.9% of the traditional-type patients stayed abstinent during the entire 1-year follow-up period. Consequently, the Hazelden-type treatment obtained better results in 1-year abstinence rate than a more traditional-type treatment⁸.

Nevertheless, there is a dearth of literature examining the effectiveness of the Minnesota Model and hence many of the references in this report are dated. Later studies that included, but were not limited to this treatment approach, found effects were inconclusive. Furthermore, this coincided with an increasing trend within the literature where treatment retention became the proxy measure for client outcomes rather than treatment modality per se.

METHODOLOGY

The theoretical approach that guided the research was process driven, as well as involving structural indicators.

Aims and objectives

The aims of this evaluation were twofold:

- To assess the effects of Tabor treatment programmes(s) across Tabor Group.
- To offer independent examination of the efficacy of the programme(s) as well as the 'goodness of fit' of the treatment model.

Objectives

- To consult with relevant stakeholders, (clients, family members, frontline staff, managers, board members, key-informants and referral agents).
- To review international and national research on the potential impact of the Minnesota Model of Treatment.
- To assess both structural (who) and process (how) indicators of outcomes across the range of services within Tabor Group.
- To make recommendations based on these findings.

Desk research

An analysis of the annual reports of Tabor Group from 2013 to 2017 was conducted. The purpose was to show similarities as well as differences across the three services within Tabor group.

Data collection

Data collection took place from September 2017 to June 2018.

Data collection comprised two key components:

1. Qualitative (interviewing and focus groups)
2. Online anonymous submission

Qualitative Interviews

A significant strength of qualitative data is the rich thematic texture that can arise from this type of analytic undertaking. The primary goal within this segment of evaluation is the elaboration of the understanding of the process of treatment, a goal that is not possible to capture in a methodological format such as a quantitative survey, which is more appropriate with larger sample sizes. A total of 34 participants were interviewed (staff members [16], clients [11], family members [3], board members[2] and key informants [2]). The majority of interviews were conducted face to face. However, to accommodate participants some were conducted by phone (8). All staff and board member interviews took place in Tabor Group services. Client and family member interviews were conducted in a neutral office in the centre of the city. All interviews were approximately 45 minutes long.

Focus Groups

Focus group research includes as many perspectives as possible, seeking to explore attitudes, feelings, beliefs and experiences (Denscombe, 2000, p.115) regarding the focus of the inquiry. This interaction between participants emphasises their view of the world, the language they use and their values and beliefs about a situation⁹. This interactive factor also enables participants to ask questions of each other, as well as to re-evaluate and reconsider their own understandings of their specific experiences¹⁰. Family members availing of treatment and support at Tabor Lodge regularly meet as a group. Thus, to accommodate the schedules of family members outside treatment and other life commitments, it was decided to facilitate a focus group. Two family members attended. Two other family members who could not attend opted for a phone interview. The focus group lasted 80 minutes and was conducted in a neutral

office in the centre of the city. Similarly, five young people who had attended treatment across the three services of Tabor Group took part in a focus group. These were comprised of both persons who had completed treatment and those who had left early or been discharged.

[Individual online anonymous submission](#)

To ensure that we facilitated an open consultative process of participation in the evaluation, we built in a mechanism whereby all staff, board members and referral agents (regardless of whether they were selected for interview) were given the opportunity to make an online submission. The link to an anonymous survey monkey space was embedded in an email and sent to all staff, board members and referral agents. The submissions to referral agents and staff/board members were separate. However, with either group's experience in mind (referral or work) they were given three questions: What works? What does not work? What would you like to do differently?). Each question had an open space (which was limited to 500 words per question, i.e., each submission is limited to 1500 words). The submissions were completely anonymous, to give participants an opportunity to share their experience. The purpose was twofold: (i) capture individuals who could not take part in an interview or (ii) allow participants who did take part in an interview but wished to express a concern/issue anonymously.

Participants

A total of 58 participants took part in the current study (34 interviewees, 7 focus group participants, and 17 individuals who made written submissions).

Recruitment

As participants were varied several recruitment strategies were necessary.

Staff members of Tabor Group

All staff members were invited for an interview. This included clinical staff (counsellors/psychotherapists), the quality and risk manager, an admissions officer, the General Manager, clinical director, support staff, administrative staff, the family service development officer and all three managers from Tabor Lodge, Renewal, and Fellowship-House. Each member of staff was contacted via email by the researcher (JI) inviting them to interview. It was made clear in the email that this was a voluntary process. Also, all staff members received an email with the electronic link to the anonymous online submission.

Board members

Two of the ten board members were randomly selected from the full list of members. Moreover, as there is only one founding board member active, and given the significance of this role to the treatment model, this person was automatically selected for an interview. In addition, all board members received an email with the electronic link to the anonymous online submission.

Referral agents

Tabor Group has a master list of all referral agents who have referred a client/patient for treatment in the last 12 months. All agents were sent a letter via email inviting them to make an online submission. Participants were provided with an anonymous space within Survey Monkey.

Clients

The study was interested in recruiting two categories of service users (i) those who completed the programme [both past and current] and (ii) those who left prematurely hence forward referred to as non-completers. Non-completers included those who left the programme and those who were discharged by the service.

The client recruitment strategy was as follows:

(i) Completers

Current participants on Tabor programme were informed that a research study was running and posters were displayed on premises inviting service users to participate. Having obtained service user details, the researcher contacted the service user by phone to give information on the study. Once they indicated a willingness to participate the following steps were taken:

1. A copy of the participant information sheet and consent form was posted to their home.
2. An interview time was set for the following seven days.

(ii) Non-completers

As non-completers were less likely to be in contact with Tabor Group, non-completers were recruited through referral agents and the Cork/Kerry service user representative. Both the service user representative as well as the full list of referral agents to Tabor Group in the last 12 months were contacted via email and asked to display posters in public areas of their offices and clinics inviting service users to participate in the research. The purpose of this was to recruit previous clients of Tabor Group who entered but did not complete a Tabor Group programme. Once interested clients were identified, the researcher followed steps one and two above.

Family members

The family members group was made up of family members of current and past clients who had both completed and not completed programmes at Tabor Group. The researcher (JI) sent an email via the family support programme which was forwarded to family members. Family members who wished to participate in the focus group or interviews made direct contact with the researcher by responding to the email.

Ethical approval

The study received ethical approval from Trinity College Dublin, Faculty of Health Sciences (FHS) Research Committee.

FINDINGS OF DESK RESEARCH

The following section presents data from figures provided in the annual reports of Tabor Group from 2013 to 2017. The purpose is to show similarities as well as differences across the three services within Tabor Group while also examining figures in terms of national and European treatment figures. Trends in demographics, referrals across the continuum, service utilisation as well as presentation of complex needs are presented by service below.

Client profile and data trends across Tabor Group

Table 1: Tabor Group service profiles:

| Service | Tabor Lodge | | Renewal | | Fellowship House | |
|-------------------------|------------------------------|-----------|-------------------------------|-----------|-------------------------------|-----------|
| Services offered | Residential 28-day programme | | Residential 12-week programme | | Residential 12-week programme | |
| Clients profile | Mixed gender | 18 years+ | Females only | 18 years+ | Males only | 18 years+ |

The age range of clients receiving treatment from either Renewal or Fellowship House remained relatively stable across the five-year period. However, the average age of clients for both services was different. The majority of clients (n=26) at Fellowship House were aged between 18 and 24 years, while the comparative figure for presentations to Renewal for this age group was half (n=13). Both Tabor Lodge (n=70) and Renewal (n=16) report the highest presentations in the 25 to 34-year old category.

Table 2: Five-year (2013-2017) figures across Tabor group by age and service:

1: Client data are reproduced from data provided in annual reports from 2013-2017

| Age | Tabor Lodge | | | | | Renewal | | | | | Fellowship House | | | | |
|--------------|-------------|------------|------------|------------|------------|-----------|-----------|-----------|-----------|-----------|------------------|-----------|-----------|-----------|-----------|
| | 2013 | 2014 | 2015 | 2016 | 2017 | 2013 | 2014 | 2015 | 2016 | 2017 | 2013 | 2014 | 2015 | 2016 | 2017 |
| 18-24 | 34 | 37 | 29 | 26 | 23 | 12 | 17 | 13 | 11 | 13 | 20 | 28 | 28 | 34 | 21 |
| 25-34 | 74 | 51 | 62 | 59 | 70 | 20 | 14 | 10 | 20 | 14 | 15 | 11 | 11 | 13 | 15 |
| 35-44 | 44 | 60 | 55 | 58 | 64 | 10 | 9 | 9 | 13 | 11 | 10 | 8 | 8 | 1 | 11 |
| 45-54 | 20 | 18 | 23 | 19 | 34 | 7 | 4 | 12 | 10 | 5 | 3 | 1 | 1 | 1 | 2 |
| 55+ | 47 | 44 | 49 | 39 | 17 | 1 | 2 | 3 | 3 | 3 | 1 | 0 | 0 | 1 | 0 |
| 65+ | | | | | | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 219 | 210 | 218 | 201 | 208 | 50 | 46 | 47 | 57 | 46 | 49 | 48 | 48 | 50 | 49 |

Demographically each of the three services is quite different. More than two fifths of Tabor Lodge clients are employed, while on average 6% of Fellowship House are employed. Not surprisingly, Tabor Lodge clients are more educated with almost one fifth reported as having a third level education.

Table 3: Tabor group client demographics

| Demographics ¹ | Tabor Lodge | | Renewal | | Fellowship House | |
|--|-------------|---------|-----------|--------|------------------|--------|
| Employed² | Yes % | No % | Yes % | No % | Yes % | No % |
| | 43 | 57 | 11 | 89 | 6 | 94 |
| Accommodation | Yes | No | Yes | No | Yes | No |
| | 94 | 6 | 77 | 23 | 31 | 69 |
| Highest level of education | Secondary | Third | Secondary | Third | Secondary | Third |
| | % | % | % | % | % | % |
| Relationship status³ | 70 | 18 | 62 | 33 | 84 | 10 |
| | Partner | Single | Partner | Single | Partner | Single |
| | % | % | % | % | % | % |
| | UNKNOWN | UNKNOWN | 11 | 79 | 7 | 93 |

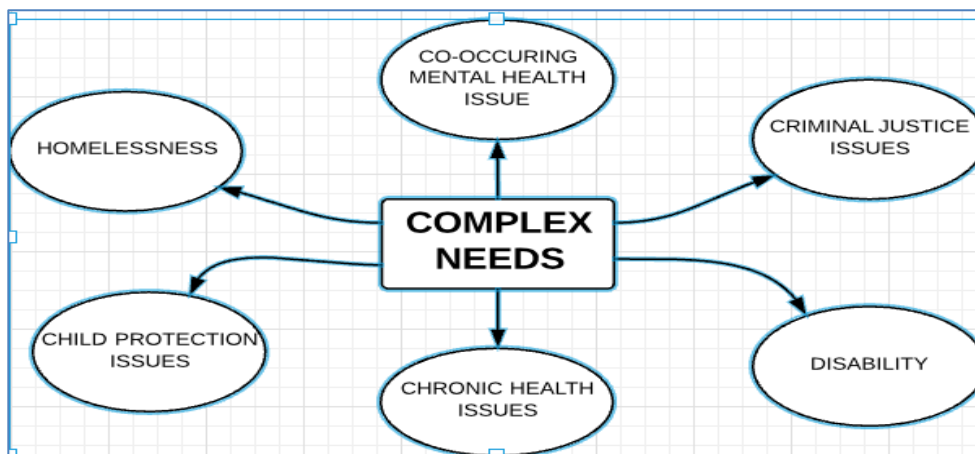
1: Demographics are averaged over 5 years based on sum of data provided in annual reports from 2013-2017

2: Excludes housewives/husbands/unable to work or retired

3: Married/partner amalgamated, single/separated/divorced/widowed/other amalgamated

The presentations of complex needs (see Figure 2) are significant for both Renewal and Fellowship House.

Figure 2: Complex needs



Nevertheless, the type of complex needs varied considerably between the two services. Family ‘addiction history’ was considerably higher in Renewal with more than two-thirds of client presentations. Similarly, homelessness was reported in two-thirds of clients presentations at Fellowship House. More than half of presentations at Renewal had a history of abuse.

Furthermore, almost half of clients at Renewal were reported as having a psychiatric history, compared to less than one third of Fellowship House clients.

Table 4: Tabor group client complex needs

| Complex needs ¹ | Renewal % | Fellowship House % |
|----------------------------|-----------|--------------------|
| Family addiction history | 69 | 47 |
| Homeless | 26 | 68 |
| Psychiatric history | 47 | 32 |
| History of abuse | 57 | 46 |
| Judicial involvement | UNKNOWN | UNKNOWN |

1: Complex needs are averaged over 5 years based on sum of data provided in annual reports from 2013-2017. Data on complex needs not collected for Tabor Lodge

Alcohol is the highest recorded substance of choice across all three services. Ecstasy, cannabis and cocaine were ranked highest reported drug of choice for clients of Fellowship House. Similarly, cannabis and cocaine were ranked highest reported drug of choice for clients of Renewal. A number of trends emerged from the data. In 2016 and 2017, headshop drugs were reported as drug of choice for more than half (on average 51%) of Fellowship House clients. Moreover, prescribed medication as a drug of choice increased by almost 10% (64% in 2013 to 73% in 2017) in the 4-year period reported by Fellowship House, while presentation of gambling went up exponentially (from 2% in 2013 to 22% in 2017). Food as a drug of choice was reported by Renewal for almost one-third of clients (on average 30% from 2013 to 2017) and has steadily grown from (24% to 34% 2013 to 2017). Opiate figures (methadone and heroin combined) were reported in less than one-third of Renewal’s figures and just over two fifths (45%) of Fellowship House figures.

Table 5: Client drug of choice by service

| Drug of choice ¹ | Renewal % | Fellowship House ² % |
|-----------------------------|-----------|---------------------------------|
| Alcohol | 94 | 93 |
| Ecstasy | 47 | 87 |
| Cannabis | 63 | 91 |
| Cocaine | 53 | 85 |
| Heroin | 15 | 27 |
| Methadone | 14 | 18 |
| Speed | 39 | 74 |
| LSD | 20 | 51 |
| Prescribed medication | 57 | 72 |
| Headshop ³ | - | 50 |
| Gambling | 5 | 14 |
| Food | 30 | 10 ⁴ |

1: Drug of choice are averaged over 5 years based on sum of data provided in annual reports from 2013-2017. While the question states 'drug of choice' it reports all drugs used. No rank or order is recorded.

2: Figures for Fellowship House are reported on 4-year average, as data for drug of choice was not included for 2015

3: Headshop use was only reported in Fellowship House figures and is based on 2016 and 2017 figures only

4: The Fellowship House figure for food is based on the 2017 absolute figure as no other data for food reported for the preceding year

As the drug of choice was recorded differently for Tabor Lodge figures are presented in table 5a below. Alcohol and cannabis were the leading drug of choice with cocaine following. No use of head shop products was recorded and ecstasy use is in the minority, unlike presentations at Renewal and Fellowship House. No data is reported for gambling or food.

Table 5a: Client drug of choice by service

| Tabor Lodge | 2013 | 2014 | 2015 | 2016 | 2017 |
|--------------------|------|------|------|------|------|
| Drug of choice | % | % | % | % | % |
| Opiates | 4 | 3 | 5 | 7 | 5 |
| Ecstasy | 4 | 2 | 1 | 1 | 1 |
| Cocaine | 9 | 9 | 11 | 10 | 15 |
| Other Stimulants | 0 | 0 | 0 | 1 | 1 |
| Benzos | 7 | 10 | 10 | 9 | 11 |
| Volatile Inhalants | 0 | 0 | 0 | 1 | 1 |
| Cannabis | 17 | 15 | 12 | 16 | 14 |
| Alcohol | 50 | 57 | 53 | 51 | 47 |
| Other Drugs | 1 | 0 | 1 | 2 | 1 |
| Other Problems | 8 | 4 | 7 | 2 | 4 |

Overall the referral pathway from Tabor Lodge to both Fellowship House and Renewal is modest. On average less than one-third of referrals to Fellowship House in the last five years came from Tabor Lodge. Similarly, less than one-quarter of referrals to Renewal in the previous five years came from Tabor Lodge (Table 6).

Table 6: Referrals from Tabor Lodge to Renewal or Fellowship House

| Tabor Referrals to Secondary Tabor Treatment | | | | |
|--|---------|------|------------------|------|
| Year | Renewal | | Fellowship House | |
| | N= | % | N= | % |
| 2013 | 12 | 24 | 13 | 27 |
| 2014 | 11 | 24 | 14 | 30 |
| 2015 | 14 | 30 | 19 | 37 |
| 2016 | 15 | 26 | 19 | 38 |
| 2017 | 8 | 17 | 13 | 27 |
| 5 year average | 12 | 24.2 | 15.6 | 31.8 |

1: Referrals are averaged over 5 years based on sum of data provided in annual reports from 2013-2017

Two thirds of referrals to Tabor Lodge were either self or family referrals. A further 10% came from combined health professional referrals, with less than 10% from other drug treatment services (9%) and employers (7%) (Table 7).

Table: 7 External Sources of referral to Tabor Lodge

| External source of referral to Tabor Lodge ¹ | % |
|---|----|
| Self | 42 |
| Family | 22 |
| Friends | 3 |
| Employer | 7 |
| Other drug treatment service | 9 |
| General Practitioner | 3 |
| Hospital/medical agency excluding A&E | 4 |
| Mental health facility/professional | 3 |
| Social services | 3 |
| Judicial services | 2 |
| Outreach | 2 |

1: Source of referral is averaged over 3 years 2015-2017 based on sum of data provided in annual reports

The majority of referrals to both Renewal and Fellowship House come from external drug treatment services (Table 8).

Table 8: External sources of referral to Renewal and Fellowship House

| External source of referral ¹ | Renewal % | Fellowship House % |
|--|--------------|-----------------------|
| Self | 2 | 5 |
| Other drug treatment service | 73 | 66 |

1: Source of referral is averaged over 5 years 2013-2017 based on sum of data provided in annual reports

Occupancy levels remain relatively stable across the three services (Table 9)

Table 9: Occupancy level by service

| | Tabor Lodge | Renewal | Fellowship House |
|------|--------------------------|--------------------------|--------------------------|
| Year | Average Annual Occupancy | Average Annual Occupancy | Average Annual Occupancy |
| 2013 | 79 | 98 | 98 |
| 2014 | 76 | 97 | 94 |
| 2015 | 82 | 92 | 92 |
| 2016 | 80 | | |
| 2017 | 80 | | |

1: Occupancy based on data provided in annual reports from 2013-2017

Discussion of findings

Tabor Lodge, Renewal and Fellowship House, while collectively referred to as Tabor Group, offer distinct services. Although each service provides addiction treatment they are responding to different client cohorts. Clients were distinctively different in age, gender, demographics and clinical presentation. These differences are discussed across Tabor Group and also within the context of national and European treatment presentations. The majority of clients in Fellowship House are in the age category of 18-24 years old while Tabor Lodge and Renewal clients are in the 25-34 years old category. According to the National Drug Treatment Reporting System the mean age at presentation for treatment for drug and alcohol is 35 years in Ireland.

Demographically, each of the three services is quite different. The presentations of complex needs are significant for both Renewal and Fellowship House. Nevertheless, the type of needs varied considerably between the two services.

Family addiction history was considerably higher in Renewal with more than two-thirds of client presentations. Similarly, homelessness was reported in two-thirds of clients' presentations at Fellowship House. The longer a person is homeless, the more likely it is that they will suffer from addiction¹¹.

Women attending Renewal reported abuse at a much greater rate than their male counterparts at Fellowship House, a finding that is directly in line with national and international scientific literature. Research demonstrates disproportionately more women with substance use problems are victims of domestic violence, incest, rape, sexual assault and child physical abuse¹²⁻¹⁴. The National Center on Addiction & Substance Abuse at Columbia University has found that girls who report having experienced physical or sexual abuse are twice as likely to smoke, drink or use drugs as those who were not abused. In addition, women attending Renewal reported a higher incidence of psychiatric history. Women's mental health may also suffer excessively as women often experience more stigmas due to addiction than their male counterparts¹⁵.

Alcohol was the leading drug of choice for clients across Tabor Group, a finding that is in line with national figures. According to the HRB alcohol remains the main problem drug from which people seek treatment in Ireland¹⁶. Opiate figures (methadone and heroin combined) was reported in less than one-third of Renewal's figures and just over two fifths (45%) of Fellowship House figures. However, in 2016, the use of opioids (mainly heroin and methadone) were reported as the main reason for entering specialised drug treatment in Europe¹⁷.

Ecstasy, cannabis and cocaine were ranked the highest reported drugs of choice for clients of Fellowship House. Similarly, cannabis and cocaine were ranked highest reported drugs of choice for clients of Renewal. Since 2014, there has been a steady increase in the proportion of new cases for treatment reporting cocaine as the main problem drug in Ireland, rising from a low of 297 cases in 2013 to 568 cases in 2016¹⁷. Likewise, there has been an increase in Europe in the number of first-time entrants to drug treatment services with cocaine as a main problem drug.

A number of trends emerged from the data. In 2016 and 2017, New Psychoactive Substances (NPS) were reported as the drug of choice for more than half of Fellowship House clients.

TCD

Nationally there were 72 entrants to treatment in 2016, for whom an NSP was the main problem drug¹⁷.

QUALITATIVE FINDINGS

Findings from both the qualitative interviews and the focus groups are presented collectively as qualitative findings.

Qualitative interviews

Thirty-four participants took part in the qualitative interviews. This consultation included the experiences of clients and family members from across Tabor Group frontline workers, managers, board members, referral agents and key informants. The qualitative data yielded crucial information on the experiences of frontline workers and their managers as well as referral agents and key informants working with Tabor Group. Clients and family members' experience yielded crucial insights into treatment programmes they had received. There were three themes: what works, what does not work, and changes they would like to make. Several subthemes emerged from the data. These data are presented and discussed regarding their respective themes and subthemes.

Focus groups

Two focus groups were conducted, one with family members (n=2, 1 spouse and 1 parent) and one with young people (n=5) who had gone through a Tabor Service (1 completer, 3 non-completers, and 1 current).

STAFF, BOARD MEMBERS AND KEY-INFORMANTS

As the number of managers and key-informants were quite small and potentially identifiable all participants (staff members, board members and actual key-informants will be referred to simply as participants).

WHAT WORKS

Staff members acknowledged the support that they received from their highly skilled colleagues.

Support

“Now, I do get the satisfaction and you can’t beat that and I have the peace of mind of knowing that I’m backed up in any decisions that I need to make, if I’ve to make something very quick or whatever, the – [managers name removed] is more – more than supportive” (participant 1).

“We always had good fun here, good support here, you know, a very clear healthy working environment” (participant 4).

“Excellent colleagues...I have highly skilled colleagues that really know what they are about, you know...” (participant 3).

Staff members and key-informants noted both the commitment and dedication of staff at Tabor Group.

Dedicated/committed staff

“The first thing, well I might be speaking about myself here now but – but I think the – the biggest successes would be the – really the long retention of staff in Fellowship House. We’ve had very little in the line of turnover” (participant 2).

“Their [Tabor Group] staff are good to work with, they’re very good to communicate with us and liaise –liaise with us” (participant 1).

Board members, staff and key-informants perceived that Tabor Group had a good reputation.

Reputation

"I mean you already have, you know, a really good reputation anyway. So it's not, there's a lot here that isn't broken, doesn't need to be fixed?" (participant 6).

"The reputation we have speaks for itself...we have an excellent reputation, not just at county level – nationally!" (participant 1).

"I think what works is the good name.....We've a very good reputation" (participant 4)

Board members and staff acknowledged the local support of the Health Service Executive (HSE)

HSE support

"I believe the HSE in the south and the drugs force in the south is extremely good to us" (Board member 1).

"The support that we're getting from the HSE...the local drugs taskforce, the southern region taskforce. They're all very willing to assist us in whatever way possible. I know they're caught as well with the money that they can get but I honestly believe that they're getting good value for the money that they give us" (participant 7).

The perception amongst key-informants was that the programme fits well with client needs

Good fit

... I think clients have been met very much where they're at, they're – their needs around addiction get very well and effectively met I believe. They have good structure in their programme and that might also be a fit as well if the client needs a fairly structured environment and programme that will determine Fellowship House as well as being a good fit. So they've good structure and fit in their programmes (participant 8).

“Fellowship House. I’m just trying to think what else works well, I think the – I think what works well as well is the continuity, they get continued support if they choose to stay in the Cork area, they get continued support. They’re also good to refer clients back, directly back to us when they’ve completed. So they then re-engage in our continuing care and that could be either in Cork or in Kerry and they’re – that works well so people don’t fall through – through the cracks or they don’t fall between the two” (participant 3).

“I suppose what works well, the – I think they liaise very well with us and communicate very consistently and very well with us in relation to clients both prior to the referral, post the referral interview, and up to admission. The – what would I say, the – they’re very receptive I suppose feedback and – and learning from the client’s experience and adapting to fit these because we’ve had a few conversations around that and I’ve found them very open” (participant 8).

WHAT DOES NOT WORK

The notion of Tabor Group as a single entity elicited mixed responses from participants. However, the majority of staff did not believe that Tabor Group was a single cohesive group.

Tabor as a group

“...Not at all [a group] sure that’s just for the brochure...” (participant 6).

“...I don’t think we are a group per se.... there is effort every now and then from the board, but the programmes are all independent. Sure we can’t get a place in renewal for love nor money...” (participant 6).

“I think it has become more than that [three services] and I think that – I think the evidence of that is – is more visible now. Maybe at a clinical level I think maybe there is room for there to be more consistency in approach and I suppose an example of that would be, let’s say, Fellowship House: if you leave there regardless of your – your therapeutic needs and that, you do not get an opportunity to come back even if you make a rash decision, whereas in Renewal which is a service meant to be very like – or, you know, very much part of the same organisation there is much more – there is a policy there that is much more open to meeting a client, looking at the difficulties why they left and re-engaging with them” (participant 8).

Staff noted the varied needs of clients presenting across Tabor Group and the effect that these needs have on addiction was emphasized.

Varying needs of clients

“People have complex needs and other people don’t have complex needs, they have addiction. And we give the support that we can give that’s enough to stabilise and get people back on their feet, so that balance is there. Finding that balance is difficult all the time” (participant 4).

“Homelessness in – in a world that all the structures are really corroded and you’re asking somebody to remain – to try and get sobriety when their – all of those other issues might be around for them as well” (participant 8).

“We’ve come a long way since 27 years ago when Sister Margaret started and you were dealing with the honest to God salt of the earth alcoholic. He’s not there anymore or she’s not there anymore, you know, ‘tis alcohol, drugs, gambling, sex addiction, and so much other stuff” (participant 3).

Lack of resources

“I would say maybe with change of staff within the past year that [treatment] has probably suffered somewhat” (participant 2).

“I suppose best practice is that you don’t do group on your own. And, you know, I think it surprised people the amount of time that staff were on – or were in group on their own” (participant 5).

“We are drastically understaffed” (participant 4).

Administration was perceived as burdensome and often perceived as an inappropriate use of time.

Admin burden

“I understand, listen, we all have to have policies and procedures and they’re there for safety reason. To, you know, keep me safe and to keep clients safe but clients aren’t coming here for health and safety awareness, they’re coming here for addiction treatment and they need to be heard and they need to be sat with and they need to be challenged

and they need all that stuff. And if my time is taken up with putting numbers on all the files, you know, a number up in the corner on each file (participant 1).

"...forms and forms and policies come on when a client is dealing with addiction and I am asking them to stop will I complete my form... come on? (participant 6).

Staff frequently felt unsupported and undervalued, particularly at vulnerable times. A number of staff members referenced lack of support they had around the time of a bereavement. This in turn was taking a toll.

Unsupported

"...of course the clients are going to see it if you're not, so if you're not happy in your job and things, you know, if you're not being heard and you're becoming resentful, like, obviously that's going to be picked up even by the clients. So, like, the team to me is the most important (participant 1).

"caring industry, as they call it, is not so caring" (participant 2).

"I think it's a bit hypocritical from the point of view that we're there in a caring profession and I don't think enough of care and attention is given to looking after staff, supporting staff. Encouraging them, you know, and I think acknowledging them for the volume of work and tough work that they do" (participant 3).

"You know, we're supposed to be working from these, what they call, core values, okay? So, there's respect, compassion, justice, yeah? Team and excellence. Okay? All sound fantastic and they do work when they're put into place but I – I think what needs to happen is that all these are firstly applied to the staff and number one being respect. And number

two being compassion and I have to say in my experience I didn't experience that"
(participant 6).

Break in the continuum

"from our perspective and some of the clients that don't get – don't get to secondary, it's because of the wait being too long"

Staff acknowledged the often-confrontational nature of the programme(s) across Tabor Group.

Confrontational treatment

"...we will at times be concerned about some clientsyou know, 'they're going to find this tough, I hope that they will last long enough to settle into the programme' (participant 3)..".

"It [the programme] can be pretty tough at times... I mean it is in your face" (participant 6).

The 28-day programme at Tabor Lodge was seen as too short by the majority of staff

Length of treatment too short

"I suppose in looking at 28 days is a short space of time...Its too short...to work with somebody, so it's a sort of short, sharp shock dose of treatment...I do think time limitation in that way is one of the things"

That 28 days ain't gonna cut it for most people, you know? For anybody, you know?

WHAT CHANGES WOULD YOU LIKE TO SEE HAPPEN WITHIN TABOR GROUP

Staff made several programme and systemic recommendations

Programme changes

“I think it’s a service that could be more trauma informed and more trauma-sensitive and I think the confrontation – the confrontational nature of their experience there reflects maybe a lack of sensitivity or awareness of the trauma that people are carrying with them and they just don’t cope. So they usually leave earlier, so I suppose we have – that’s a piece that we have – there’s a higher rate of people leaving earlier from our experience from Renewal and usually the people that leave earlier are the people that most need it” (participant 8).

“I would like to – to see it to have 12 step understanding at its core, language or re-linguaged but embracing a lot more of the current understanding and newer approaches... trauma and informed understanding of clients... mindfulness-based treatments” (participant 5).

Systemic changes

“One of the things maybe to see how each of us work, to get to observe how each work so that what we’re doing in Tabor Lodge is sort of in some way part of the continuing treatment rather than doing this in Tabor Lodge and something very different – my sense is that that happens but I think it could happen in a far more seamless way if we were all maybe singing from a similar hymn sheet”.

“A team that will prioritise the transition. To prioritise – prioritise the needs of Tabor Group, Tabor Lodge patients into the extended care units and then that there’s a directive almost and the management group agree that they will achieve that. And you’re suggesting maybe the assessment teams come in then and set up the mechanics of that and pilot it ...” (participant 4).

“So, there is – there is some kind of a shakeup, I think that’s a really good word, that there is some kind of a shakeup there needed in that environment to – to bring that about. I think the overall principles and approach of the programme are quite appropriate but there is, I think there is some kind of a shakeup – I think it may actually just be down to having very good staff retention so you end up with the very same personnel and patterns becoming very set” (participant 8).

“I probably would have to come back to the need for recognition of staff” (participant 6).

CLIENT QUALITATIVE FINDINGS

WHAT WORKS

Aftercare was noted by clients as something that really worked well.

Aftercare

“Its [women’s group] totally different the way I suppose aftercare really is – like your group in Tabor whereas the women’s is totally different and it’s really beneficial. You know, you’re up – first of all you’re meeting people that you haven’t seen before, whereas in group you’re kind of linking up with people who have been in Tabor - a few of them, you know, whereas the women’s – it’s a totally different agenda, it’s kind of like, you know the way in group you’re listening to the men’s problems and they’re totally different [laughs]. Whereas the women’s day, it’s a real bonding session and I think that’s where you make your friends, you know, well in the fellowship you make friends too but I think” (client 1).

The positive attitude of the staff was appreciated by a number of clients.

Staff attitude

“They have really [speaker’s emphasis] gone over and above, there was no stigma, there was no shame, there was no second glances or, you know, ‘you didn’t get it the first time so there’s going to be a stick on your hand’ nothing. They were phenomenal, very professional” (client 1).

Small groups were seen as a definite component that worked and were valued by clients.

Small groups

“Unfortunately there’s only one Renewal for women and I wouldn’t like to see the group getting any bigger because it’s the beauty within it because that’s why I think it has worked” (client 1).

“...In Tabor Lodge we were split into two separate groups, there was more of us inside and when we were in Fellowship House, it was just one small group of us. It kind of got us to know more about the other person, the other people that are inside because they were doing their Step 1s, they were doing their consequences and they were getting family letters in. But in Tabor Lodge that’s all we were getting was people inside our group... you didn’t really get to know people...” (client 2).

Completing treatment was really good for clients and made them feel good.

Completing

“...that’s why finishing Fellowship House was such – meant so much – like, the keyring I have in my pocket all the time and it just kind of means so much that – and just my – just the quality of life I have now, you know? It’s – of course it’s not perfect but, Christ, it’s a lot better than it was last year”... (client 4).

“...Tabor Lodge was the first thing I think I completed in my life...” (client 5).

The treatment model framing addiction as a disease was seen as a positive by clients.

Minnesota Model of treatment

“...it really opened my eyes to what – to what was wrong with me, the fact that it was a disease and the fact that I had this. But when I went on to Fellowship House when I came out of Tabor Lodge I was – I still wasn’t – I still didn’t really feel that comfortable, I suppose

comfortable to the outside world, really, going back into the – into the kind of, you know, normal – being around normal people again. And what Fellowship House did for me – because that was a 12 week – that was 12 weeks in there and it was residential but you were able to go out, go to meetings, start going out into the city with guys who were with you, you know, in the – in the treatment. And I think what that did was – it really set me up for how I was going to live the rest of my life with this disease” (client 4).

“the model, the 12 step thing really stuck with me and seeing addiction as a disease allowed me have more compassion for myself” (client 5).

Naturally the financial support was a real positive for the clients.

Financial support

“...I was waiting for was Tabor Lodge and I was – when I finished up there I thought I was going to have to wait until this year to get into the house, January I was supposed to be in because I was waiting for a grant but someone out there was looking down on top of me and two grants in one year...” (client 2).

“...it was great...I got a grant from the HSE to get in... I never even knew that was possible until my counsellor told me...” (client 5).

WHAT DOES NOT WORK

The cost of treatment was perceived by clients as a direct barrier to accessing treatment at Tabor Group.

Financial barrier

“...It was the most expensive by far that I thought I wouldn’t be able to afford it, so that’s why I never – I would have chosen it first I suppose initially only that the funds weren’t there, so...” (client 1).

“...I was lucky... there’s people out there that’s crying out for help, if they were able to get funding as – able to get funding easy, some people live on the streets and just – they’ve no choice... like” (client 6).

Breaking treatment from primary to secondary treatment was viewed as a negative by clients, with the option of seamless transition seen as optimum.

Break in continuum of care

“...I finished up in October from Tabor Lodge and the December I went to Fellowship House. I kind of, I wanted it so bad, the kind of gap where I was stuck in inside the environment for the four weeks and being left out, you know, is pretty heavy for anyone. To go straight back off using, you know what I mean, you’re just given – you’re being taken out of society, getting away from people, places and things that you you’re used to using with and so inside for the 28 days and thrown back out to go anywhere. Some people, if they’re lucky, they get to go from Tabor Lodge straight to Fellowship House” (client 2).

“I had about two and a half weeks [break in treatment] I had. Yeah. So – two and a half weeks when I came out of Tabor Lodge before I went into Fellowship House. That’s a very vulnerable – that for me is the danger zone I think” (client 6).

Clients did not always see the benefit of the confrontational approach to treatment.

Confrontational treatment approach

“I was sitting there going ‘oh my God, what have I walked into? What have I walked into? I don’t believe that a counsellor could be saying something like that to someone. I don’t see any benefit in it. I honestly don’t see the benefit in it, like. So, I braced myself then because I said ‘Jesus, like ...’” (client 3).

...“I don’t think they understand or have enough training in it. It’s not helpful to people who struggle with it I think. Yeah, like, it’s like I was very, very unhappy and very down and it wasn’t changing and I actually had to go because I was getting worse. I was feeling more down the longer I stayed so I had to go...” (client 5).

... “there was certain things that, like, do you know if you’re – it’s like the more power they use, like, ‘we’re sitting here in this position, you have to, you have to [speaker’s emphasis] speak about this’ and I don’t see the benefit of sitting there calling somebody names or the counsellor sitting there calling somebody names. I don’t see the benefit of that, I really don’t. And okay, that works for some people and that’s good, like, that works for some people but I find when it’s taken to an extreme - I get they’re trying to break you down, I get – I understand that but I don’t understand either. Because they – you don’t know if you’re – anyone could be...No. It’s not healthy in any setting” (client 8).

Some clients referred to a process of the “hot seat”, which they regarded as bad practice and often felt distressed afterwards.

The ‘Hot Seat’

“The hot seats I think are the worst. They, like, there could be two or three counsellors there and they’re, like, saying things to you like you’re a nasty person, you’re not going

to this, you're going to end up – all this stuff, really horrible and then they get the group to come at you as well and say things to you and you just have to sit there and take it, like. They can be calling you every name, not really bad” (client 7).

“And one day I had a hot seat and after they gave me the hot seat they started asking me about my story ...and I had to talk about a lot of stuff that I'd never talked about before, not to anyone and not a bunch of people, and I was hysterical and I tried to get up and leave but I came back and it went on for three hours. ... Yeah, but it was really, like, I don't know the right word when [pause] – they didn't say it in a good way, like, it was just – it was horrible...” (client 9).

Clients sometimes viewed the staff attitude towards clients as a negative.

Staff attitude

“the first evening that I went in I was sitting down and I got – now obviously the meeting was at 5 o'clock in the evening and obviously I had alcohol on me because otherwise I would have been sweating and shaking and that was one thing I couldn't get my head around because they kind of got angry at me because I had alcohol on me. And I couldn't - couldn't get my brain around the fact that ‘but if I could get my head around the whole day without alcohol, well what do I have to go to a treatment centre for?’” (client 2).

“I felt, like, no-one was listening to me in there because I was so young, I couldn't get my point and I tried to say that one day and it just got thrown in my face that I was self-pitying and stuff like that just one example” (client 9).

... “they’ve [staff] an attitude...Because of our age they think we’re not as much addicts as the older people, like you know, sometimes we’re even worse than the older – like if you’re an addict you’re an addict, everyone’s the same, you know?”... (client 7).

Client viewed the 28 day treatment programme at Tabor as too short.

Treatment duration too short

...“when I finished there after the 28 days I felt like I needed a lot more inside, you know, it didn’t seem that long for me....” (client 2).

“..28 days it’s very short, like. I found it was very good down there, like, but like a lot of people said once you’re out of there you’re out of there. You get one hour a week for a year, that’s it, like...” (client 9).

WHAT CHANGES WOULD YOU LIKE TO SEE HAPPEN WITHIN TABOR GROUP

Client recommendations focused more on suggested changes to treatment programmes.

“I think maybe – one thing I think that would be good would be if there was a strong – a strong focus on the – the benefits of recovery and the positive aspects of recovery rather than the damage and the consequences of not being in recovery (client 11).

“maybe it would be beneficial to bring somebody who’s gone through the programme in Tabor, maybe after six months, after a year and just talk to them. It might make it a bit more personal for people” (client 7).

“To be more mindful of what they say to people. To be more mindful of what they say to people. There’s no need to try and crush somebody and it’s not beneficial, like, it’s not” (client 3).

“Something around housing needs to happen..I have 3 months to find a house and have no one to help me...like all the treatment I have had and ill have no house ill end up in a hostel like...”(client 8).

“There should be more support after Fellowship with housing, like we are put in Sober House and have to fend for ourselves with no support” (client 9).

FAMILY FINDINGS

WHAT WORKED

The family members were really appreciative of the support they received from their peers in group.

Supports

“I felt myself it was great. ...because I was in the group of people likeminded and ...I was talking to people that were, like me, the family or husbands, wives of the people who were gone in [to Tabor Lodge” (family member 1).

“I found that absolutely fantastic, brilliant, because, again, it’s – the facilitators really, like, if I say – that’s a lot of it but the other part of it is just the people around, you know, if we get on with those people, I know you and I accept that but then again it’s nice to be in a group of people that you really get on with, you know ...(family member 2).

“I found it – Tabor Lodge, I found it great because it was very welcoming. People listened, I used to go up every Wednesday, sometimes with my daughter too...” (family member 3).

In addition the one to one sessions were of great value.

“...there was one to one counselling if you wanted it and then my daughter came now a couple of times and found it very interesting, because she kind of – another side of her then that I didn’t know was there. Because as I say even though we were both going through it – I was kind of giving out about my problems and it was only then when she spoke herself as a person that – that I realised how she felt. And that was actually very emotional ...” (family member 1).

The aftercare programmes were perceived by family members to be really beneficial.

“And then after that – now I found the 12 weeks fantastic and then there was programmes and aftercare, it was every week for two hours and it was then followed up to the twelfth week...it was really fabulous” (family member 1).

“But I went to my 12 week programme I wasn’t aware of the aftercare until maybe towards the end and they were telling us about it just before we finished that this was for us and I thought ‘I’ll take it, I’ll take more of it because...I was just amazed to listen to all these other people who were having similar – but for me I felt – I’d still question was he an alcoholic?” (family member 2).

Importantly family members felt that the programme was really supportive regardless of the benefit to the ‘immediate client’.

“... only for it – and I always say to family members ‘Bill didn’t succeed in ...’ – even though he might have months where he doesn’t drink and then he’ll go again, and I often say to my family ‘it’s still helping me’, that programme is still helping me still in my life in every way, not just for the addict. I use it for a lot of things. My kids, I think it has helped them because I am a better person, I’m not the mad insane person that I was before because of it. And that’s exactly how I would describe myself, mad as – and I was insane!...”

WHAT DID NOT WORK

The family members had very little to say about what did not work. One recurring issue was the perceived financial barrier.

Financial barrier

“Well from my own personal experience then - it wasn’t for me but I know at the time that especially around a couple of years ago when it was very bad around the country, it was a tenner per night per person. Now the only fear I have there is that a person, even though they might need it, the fact that the €10 might be something that they need for something else, something that they feel is more important and for that reason it might actually stop them from going on Thursday night?” (family member 1).

“There would have been times where my husband would have been drinking and I wouldn’t have been given any money, so €10 – I – I did manage – I’d always make sure I had it for the meeting, but there could very well be people that wouldn’t have it and that would prevent you from going – and – and there were probably times back when it was really bad where I did miss because I needed that tenner for something else and that –

you know, if things are bad, if you have addiction, live addiction in your house, you have financial problems!” (family member 2).

WHAT CHANGES WOULD YOU LIKE TO SEE HAPPEN WITHIN TABOR GROUP

Recommendations were focused on extending the programme to younger family members.

“Well I think for my youngest daughter who was crying out for help, just somebody at the end of the phone, even online because she was looking all the time she couldn’t get anything” (family member 2).

I think my kids would have benefited from groups ...but they...they[Tabor Lodge] don’t include them” (family member 3).

Summary of qualitative findings

- Clients spoke of both positive and negative experiences across Tabor Group. The treatment model elicited mixed feeling from clients. For the majority of clients 28 day treatment was seen as not enough. Most clients had not had a ‘door to door’ transition from primary to secondary treatment. The need for a seamless transition across the continuum was emphasised.
- Staff believed that Tabor Group had a very good reputation. For the most part staff valued the support that they received from their immediate manager. However, they felt that the wider organisation undervalued them. Administration was seen as burdensome and an inappropriate use of clinician time.
- Both staff and clients noted the confrontational nature of the treatment approach and acknowledged the difficulties for some clients.

- The notion of Tabor Group was perceived by clients and staff as a collective of three services rather than a cohesive group. There was recognition that the brand had penetrated somewhat, but several structural and cultural shifts would have to occur before these services would be unified.
- A number of clients as well as staff suggested that the 28 day programme at Tabor Lodge was too short and as such made it difficult to sufficiently address presenting issues.
- Family members placed great value on the support services they received at Tabor Lodge.
- The care family members received was perceived to be comprehensive.
- There was a perception of financial barriers for some family members.
- Family members' recommendations focused on extending family care to minors.

Online anonymous submissions

The purpose of the individual submissions was to allow participants, (particularly, but not limited to, those who had not been interviewed) an opportunity to voice an important issue that would not have otherwise been captured.

Group 1: Referral agents

A total of 10 individual submissions were made from referral agents. As submissions were anonymous, no specific information is available on participants. All submissions are included in absolute in appendix 1. Please note there is no editing of words. The submissions did not vary greatly. The following is a brief overview of collective responses to each question:

[Question 1: With your overall experience of working with Tabor Group what in your experience works?](#)

Referral agents appeared to appreciate the fast access to treatment. The specific treatment model was highly valued, most notably the aftercare. Moreover, the referral agents noted the wide-ranging skills and attributes of various staff members. The transfer of clients in the main was seen as good, particularly with case-management protocols although there was some room for improvement.

[Question 2: With your overall experience of working with Tabor Group what in your experience does not work?](#)

Referral agents most commonly noted the lack of integration and adoption of the case-management framework across Tabor Group. Some difficulties were noted with particular members of staff as well as a breakdown in communication. The length of programme and inconsistencies in providing continuity between primary and secondary treatment appeared to be problematic.

Question 3: What changes would you like to see happen within Tabor Group?

Referral agents made several suggestions, most commonly regarding the need to adapt the case-management framework further, as well as placing more emphasis on a seamless continuum of care. The current treatment model while of core value needs to be extended to include other interventions and approaches such as Trauma Informed Care, with more of an emphasis on recovery. More interaction and improved communication between primary and secondary treatment across Tabor Group is necessary.

Group 2: Tabor Group staff/board members/key informants

A total of 7 individual submissions were made from staff and board members. As submissions were anonymous no specific information is available on participants. The following is a brief overview of collective responses to each question:

Question 1: With your overall experience of working with Tabor Group what in your experience works?

Staff and board members noted the hardworking, competent practices of staff across Tabor Group and the perceived good reputation of the organisation that appeared to adapt well to the changing needs of presenting clients and their families. However, there was a need to expand services and up-skill clients. The Minnesota Model did not appear to fit all. There was a highlighted need for a more strategic approach in line with updated facilities.

Question 2: With your overall experience of working with Tabor Group what in your experience does not work?

Staff and board members noted a lack of support and appreciation. There was a perceived lack of administration support, which was overburdening clinical staff. Participants suggested that management needed to take more of a strategic approach. The treatment model was viewed as outdated and needed to be updated and brought in line with evidenced-based practice.

Question 3: What changes would you like to see happen within Tabor Group?

Staff and board members suggested the need for improved communication across the organisation, with better conditions for staff. There was a perceived need for increased resources, more clinical staff, the up-skilling of staff, better facilities and further integration with relevant external agencies.

Summary of online submission findings

- The benefits of recent developments from the case-management framework were highly valued by referral agents.
- The speed at which clients could be assessed and enter treatment was greatly appreciated by referral agents.
- Recommendations were offered around the need to include other interventions and approaches such as Trauma Informed Care to the core treatment model with more of an emphasis on recovery.

DISCUSSION

Client presentations across Tabor Group appear to be in line with both National and European treatment presentations.

The presence of the Minnesota Model was evident with all components apparent, both at programme and staff level. When asked about the importance of the model, all staff believed this was crucial to the programme. However, the confrontational approach was not always welcomed and caused concern for both staff and clients.

Confrontation was not a technique used within the original Minnesota Model, but was gradually introduced into that model in stages. The first stage was the emergence of the concept of “tough love” —a concept from Al-Anon¹⁸. The use of confrontation practices such as the “*hot seat*” were re-evaluated at Hazelden and removed from the programme as they were viewed as being “*too harsh and disrespectful*”. Moreover, according to White (2007), despite the longevity of the confrontational practice in addiction treatment there is no scientific evidence to support its efficacy, and furthermore there are numerous studies citing the harmful effects, particularly in vulnerable individuals¹⁸.

There can be no doubt that confrontation as defined by White and Miller (2007, p2) as: “*profanity-laden indictments, screamed denunciations of character, challenges and ultimatums, intense argumentation, ridicule and purposeful humiliation*” should cease in addiction treatment. Nonetheless, later discussion by the authors suggests the need to ‘*rethink confrontation*’ advocating the need to ‘*rehabilitate this concept*’ (p22). Thus, the authors suggest confrontation should be utilised as a ‘*therapeutic goal*’ rather than a ‘*counselling style*’. This reconceptualisation offers a useful shift to better understand the goal of confrontation as a mechanism “*to help the client come face to face with their present situation, reflect on it and decide what to do about it*” (p22). In the absence of such a mechanism the client may never

achieve such insight. Moreover, Devine (2017) in his article on the role of counselling in the treatment of addiction suggests the use of '*gentle confrontation*' citing the counsellor as '*best positioned to assist*' in the emotional support of such confrontations, a facilitator rather than dictator? Nevertheless, the evidence suggests while there is a place for confrontation in addiction treatment it must undergo several necessary changes to be effective.

Additionally, there is no clear evidence about whether specific *types of programmes* (i.e., treatment model/ philosophies) result in better client outcomes. Rather, the research has mostly attempted to explain positive outcomes in terms of client characteristics¹⁹. Moreover, increasingly across the literature treatment retention has become the proxy measure for positive client outcomes.

There is clear, consistent and strong association between length of time in treatment and outcomes^{19, 20}. It is therefore crucial to retain clients in treatment for an adequate amount of time. Those who complete programmes are consistently more likely to have positive lasting outcomes than non-completers^{21, 22}.

Including the family in the treatment of clients from the initiation of treatment is a significant strength of Tabor Group. This type of inclusion and participation of family members is often neglected in the Irish context, a shortcoming that has received much condemnation in recent years^{4, 23, 24}.

Largely, clients with more severe problems at treatment entry are at greater risk of premature drop-out²². There is some evidence to suggest that those who are in contact with services prior to their entry to residential rehabilitation may have better outcomes than those who are not²¹. Similarly, being drug-free prior to programme entry may also result in better outcomes.

Nevertheless, the evidence suggests, if identified early, even individuals with very severe problems, including dual diagnosis, can achieve similar outcomes to those with less severe difficulties, if more intensive, individualised services are made available to them¹⁹.

Adequate support should be provided for clients with co-existing addiction and mental health issues. Priority needs to be given to developing links with psychiatric services and regular consultation needs to be a part of the programmes across Tabor Group.

Primary residential treatment and rehabilitation programmes are not stand-alone interventions. These interventions must be seen as components of an integrated package of care with community services actively involved in the client's preparation for residential admission and aftercare following the client's completion of the programme¹⁹. Several referral agents in their online submissions noted the need for more integrated care between Tabor Group and the community based addiction services. Strategies such as case-management are an ideal solution for such integration and would also in time significantly reduce the burden of administration for clinical staff.

Likewise, the continuity of care is essential for preserving advances achieved in residential treatment. Tabor Group is in a unique position in their capacity, with adequate planning and resources, to provide for a seamless transition from primary treatment through to step-down care to best ensure successful independent living. Therefore, there is a compelling argument for providing for suitable clients, inpatient Tabor Lodge beds ascribed to Renewal and Fellowship House prior to entry. This requires significant strengthening of the links across the continuum provision to ensure the seamless transition of clients between the two. Moreover, there is a

key role for the admissions officer to further develop and strengthen strategies to include members of the continuum (Renewal and Fellowship House) in the screening and assessment of particular clients prior to admission to Tabor Lodge. There may need to be an accepted period of low occupancy and delayed admission to initially facilitate this initiative.

It is noteworthy that the current assessment of the 28-day intensive residential service echoes findings from similar reviews conducted since the 1960s. Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length²⁰. The 28-day residential treatment at Tabor Lodge, while highly valued, was found to be too short for certain clients and in need of extension. In light of international evidence the current programme should be viewed as an absolute minimum with flexibility afforded to clients in need of more time.

As homelessness is a major indicator of sustainable recovery and overall client suitability for treatment, the needs of homeless clients will need to be given greater attention and priority. It is not enough that clients, particularly younger males who are already at an immediate disadvantage in the current rental market are currently given 'space and time (3 month period)' to source adequate housing to ensure continued recovery. The careful care-planning of these clients at assessment needs to be resourced so that processes are initiated and key partners are involved in the client's care to ensure the optimal chance of securing accommodation is afforded.

Tabor Group with capital assistance from Cork County Council and the Department of Housing, Planning and Local Government has just completed a major extension of facilities at Fellowship House increasing the accommodation level from 16 beds to 32.

This enables a much extended stay for some which will improve their prospects for sustainable recovery assisted by access to secure and sustainable housing. This development at Fellowship House acknowledges and is designed to address the reality that two thirds of clients presenting to Fellowship House are homeless on admission. Coupled with the continued commitment to case-management these developments have the potential for greater priority and a more progressive response to recovery.

Without the backing of a workforce that feels valued and motivated, Tabor Group cannot continue to drive change to services for the clients. Tweaking the current model, rather than fixating on staff numbers – shift towards an ‘assets’ (i.e. staff, community resources) based model. Tabor Group needs to make improvements that are already at their disposal and work with staff and involve them continually. The experience captured tells us that the dedicated staff at Tabor Group are feeling undervalued at a senior management level. They are in need of change to develop their working relationships and environment so that they are able to deliver care differently. Adequate support should be provided to support managers to incorporate better strategies for better communication and regular annual or bi-annual appraisal of staff. Given that Tabor Group are wanting to develop the cohesion of the three services appraisals should be delivered by senior management including the Clinical Director and General Manager.

IMPORTANCE OF THIS RESEARCH

At a local level the development of the evaluation sprung from Tabor Group’s Strategic Plan, which calls for an exploration of the options to have greater flexibility in the duration of the primary residential treatment programme, an exploration that is of utmost importance to the group.

In the main, scientific research and programme evaluation have not played a major role in influencing the development of addiction treatment services nationally¹ or internationally². The consequence of this is large disparities in the development, management and monitoring of national treatment systems. One of the major barriers to undertaking internal programme evaluation is the belief that it is complicated research, while this is not necessarily the case, evaluation can be challenging. It also involves questioning current practice even if the feedback may be less positive than anticipated. A healthy culture of evaluation is one where feedback is regularly plotted into the structure of the treatment service or system^{2,4}. By initiating and undertaking evaluation Tabor Group are leading their peers by asking these difficult questions and allowing for feedback, therefore furthering a healthy culture of evaluation.

LIMITATIONS OF THE RESEARCH

All data are self-reported and therefore open to bias. As this is an evaluation of one organisation, albeit with three services, the participant numbers are small.

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

Tabor Group are to be commended for opening their service to external scrutiny and evaluation. Tabor Group has a good reputation and is a very important part of Ireland's response to addiction, promoting and enabling recovery. There is a need for the service and also a demand and with "Supporting Recovery" being mentioned on the cover of Ireland's latest National Drugs Strategy, published in 2017, that need and demand will increase. The methodology employed in this report was chosen to get the views of a wide range of staff, clients and external stakeholders. It was inclusive in nature. As a result of the varying backgrounds of the respondents there are differing, sometimes contradictory, views expressed. Notwithstanding that there is enough consensus, from the existing literature, current policy context and responses of all stakeholders to make a series of recommendations to improve the effectiveness of the work of those employed by Tabor Group. The recommendations fall into three categories; (i) strategic management and governance, (ii) staffing issues, (iii) programme issues.

RECOMMENDATIONS

Strategic management and governance

1. The board of Tabor Group should provide leadership on the overall direction of the organisation, in particular the relationship between the three entities - Tabor Lodge, Renewal and Fellowship House.
2. The senior management team of Tabor Group should be re-structured to give equality and the perception of equality of the three constituent entities. This team should have

as a minimum a management head supported by a clinical lead. These decisions are the responsibility of the board.

3. Standardised demographic and clinical data should be recorded on each client and aggregate data published. In advance of this change Tabor Group should ensure that the organisation is GDPR compliant. When compiling annual reports Tabor Group need to agree upon clear consistent variables and/or measurements across all three services.
4. The financial assistance that is available to clients via the HSE should be communicated widely and published.
5. A communication strategy, both internal and external, should be developed.

Staffing issues

6. A series of meetings with staff should take place to discuss the findings of the report with staff and wider peers across addiction services.
7. Each member of staff should have a review of their training needs. This should be carried out by the Clinical Director.
8. The Clinical Director should ensure that the policy of staff annual appraisals are conducted.

Programme issues

9. The confrontational counselling practice referred to by a number of clients, at one of the Tabor Group facilities, as the “hot seat” should be discontinued as research now indicates that it *“has been associated with higher drop-out and relapse rates, weaker therapeutic alliance and less client change.”*
10. The 28-day limit for Tabor Lodge programme should be extended on a case-by-case basis where appropriate.

11. Additions to the core treatment model should be considered; for example, Trauma Informed Care.
12. The family treatment programme should be developed to include under 18s.
13. Seamless progression from primary care to secondary care where appropriate should become the norm.
14. Readmissions to Fellowship House should be permitted.
15. Given the recent developments in Case-management across Tabor Group and wider referall network this system should be exploited to the fullest.

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APPENDICES

APPENDIX 1: ONLINE ANONYMOUS SUBMISSIONS (GROUP 1: REFERRAL AGENTS)

With your overall experience of working with Tabor Group what in your experience works? (max 300-400 words)

The quick access to discuss referral matters with staff. The clarity of what needs to be dealt with in order to gain admission. The help, support and friendliness of staff. The short waiting time for assessment.

Fast admission Tabor Lodge offers a break from addictive behaviour Good primer for 12 step community participation Continuum of care from primary to secondary treatment

1) The Group delivers a great service and model of care & treatment meeting needs of a cohort of Service Users for whom residential treatment is a fit. 2) I value their structured aftercare (phase 3 of treatment). 3) My experience has not been very positive.

Service users talk about their experience of treatment being very useful and powerful. I find the workers approachable in Tabor Lodge and Renewal. It's really important to service users that they have structure during their treatment , so the CE schemes in secondary treatment are v important. It's convenient that the aftercare groups happen in a city centre location for accessibility for service users.

Their efficiency in organizing an assessment. Their counsellors ability to work with the variety of clients from different backgrounds. Their capacity to motivate the client into believing in a better life for themselves. The clients we refer have previously tried on numerous occasions to quit using but were never open to residential and the fact they can access residential quickly, greatly enhances their chance of an improved lifestyle. The clients afterwards will talk about their unique relationship with their counsellor.

Overall my experience of working with Tabor Lodge has been that the in-take aspect of it is quiet good, its a clear process and one can navigate it easy to get a residential treatment bed. It is however the handover back to the community which I feel does not work as well as it could. As early as a month ago October 2017 I received a call referring a man back into the community the day before his treatment was finished. I did not know the client previously and I feel the day before a release date is very rushed for the client themselves.

Overall my experience as been good overall. I find the aftercare support from Tabor Lodge is very good and counsellor and facilitators are very open to working with other agencies. It is also very good that people leave with a care plan. It is very good that secondary treatment is available. The structure and opportunity to get on CE scheme in secondary treatment is very good.

The case management framework has brought much improvement in the transfer of clients to Tabor Lodge- now when there is a client that would benefit from Tier 4 residential treatment - we can transfer the initial and or comprehensive assessment with the client's consent and this helps the client progress their care plan. There has been an openness to the transfer of clients into their aftercare programme that might have completed their primary treatment elsewhere again with the transfer of care plan documentation (initial/comprehensive assessment- current care plan. There is better communication between the services - letters phone calls when transferring of clients care plans Increased funding for beds has helped some clients

With your overall experience of working with Tabor Group what in your experience does not work? (max 300-400 words)

For me nothing at present.

Strict adherence to Minnesota Model of treatment - little customising to individual client's recovery needs. No Detox facility No parallel trauma work being offered Expensive Time gaps between primary treatment closure and admission into Fellowship House or Renewal - Not door to door

1) It's sometimes difficult to liaise directly with keyworkers/case managers on Tabor Team in relation to referrals/transfers into Tabor or from Tabor to Tier 3 Services. 2) Transfer of Initial or Comp Assessments to and from their Service is not implemented consistently under the Cork/Kerry Case Management Protocols. 3) It is often difficult to have Key Workers attend Interagency Case Management Meetings in relation to Care Plans on the occasions that these might be required under the protocols. 4)

Tabor Lodge does not communicate well at all with services outside of themselves, in my experience as a community drug and alcohol worker. It is always very unclear when they release someone from their care with a care plan that my service is attached to who exactly is responsible for making contact with service user and engaging them in their piece of work. There is never any follow up work done to even check if they are attending my service so when they have not engaged how does Tabor Lodge know?

I think Tabor lodge programme is too short. I know that people can then apply for Renewal or Fellowship , but they have to wait for a place and often relapse can happen, which deters people from continuing, or once people finish the 28 days , they then don't feel compelled to do the secondary treatment. As a Community based drugs worker, I find that service users do not know enough about community supports , and they come back into the Community after treatment , not knowing enough about the case management and how this can help. I think, that especially for clients who have many needs eg. poor family links, kids in care (but with no social worker themselves as parents), attending mental health services , probation.... services are working more together under the case management system, but mental health and social work are not engaged with it and this really is a stumbling block for many people in early recovery especially The money that people are asked to pay for the aftercare programme is a barrier to people. currently service users are asked to pay 10e to attend the aftercare groups and 15e i think for the Women's day .Women have to stay for the lunch and as the group always goes somewhere 'nice' then its another 15 for lunch. I understand to some extent why Tabor ask that people pay (and also I have heard it said that people can ask to pay less etc) , but I also see that for people in recovery, they now are contributing to bills and expenses that they didn't contribute to as much before treatment (regular home bills, rent etc) . I see this payment as a further punishment for people who've been in addiction. You don't pay these fees in Mental health services for eg. CE schemes - i may be out of date on this point, but a few years ago I found that the CE shemes were restrictive

If we refer clients to Tabor Lodge sometimes we do not get an update on how the client was progressing in treatment or whether they had completed treatment. We may not be aware of their current care plan. Sometimes we would receive an aftercare plan. Our clients would talk about the difficulty of just physically getting from Cork city to Tabor Lodge for themselves and their families.

Care plans: I have worked with clients who were both referred into Tabor Lodge and referred out from Tabor Lodge. I have found with clients who have been referred back into the community from Tabor that Care Plans have not been very well thought out. Most care plans I have worked with have all been of similar content and I have not found them very person centred or have not taken into account a persons accommodation situation, financial pressures etc, the issues I feel people really struggle with when they come back into the community. I have at times found myself doing week by week care plans/goal setting with clients as some care plans have 20 plus points on them from Tabor.

In my experience I feel that assessments for secondary treatment could take place in Tabor Lodge. The gap between primary and secondary treatment should be closed in circumstances where a person has no stable accommodation to return to in between primary and secondary treatment. Funding been unavailable throughout the year for people to avail of treatment.

Clients that are in the after care programme- if a joint care plan is being considered across services - it is difficult to arrange for facilitators of the aftercare groups to attend meetings, collaborate on joint care plans- it is more usual for the aftercare co ordinator or clinic manager to attend when it may be more beneficial for the client for their key worker to be present For clients that are transferred there is still some confusion in working out who the case manager "should" be? if a client is transferred to tier 4, it would be more beneficial to the client progressing in their care plan for their primary key worker or staff in Tabor Lodge to be the case manager as they have more day to day knowledge re the client's care plan and on going goals- sometimes the referral agent has no further role in progressing the client's care plan. The follow on bed access to Renewal and Fellowship house can be problematic- due to sheer volume of clients requesting the service - clients struggling to pay

What changes would you like to see happen within Tabor Group? (max 300-400 words)

1 Continued success to Tabor Group. More interagency working between Tabor Group and Arbour House. Referrals to come from Tabor Group to Arbour House.

Trauma Informed emphasis with parallel trauma specific interventions Door to door transfers from primary to secondary treatments A detox facility to offer a residential intervention earlier in the recovery process More integration with other modalities while holding Minnesota as a core modality so that individuals might create the bespoke treatment to meet their recovery needs More HSE beds

Case management needs to be implemented in full in all of Tabor Group Houses and not limited to those who are availing of HSE funding beds, which is currently the case. This leads to an inequity of service for clients. Some have embraced case management it while others haven't which leads to tension between the different Tabor Gp houses. I've witnessed this first hand. I was called by Renewal to mediate between two services. Renewal had requested information from Tabor Lodge which was time sensitive. Tabor Lodge had been contacted through email and phone on a number of occasions and refused to respond. I was contacted to assist Renewal in getting a response from Tabor. The client is the one ultimately who would have suffered. When I made contact with in relation to this client he seemed to knowingly put obstacles in the way. I found this behaviour bizarre and unhelpful. Communication between all houses need to be standardised.

Tabor Services would benefit from delivering consistent implementation of the Cork/Kerry Protocols at all levels of Service Delivery, using case management and interagency tools, paper trails to minimise duplication of work. 2) Where Interagency Case Management meetings are needed, I would like to see Keyworkers/ Case Managers from Tabor Group consistently attending and contributing. 3) I would like to see a partnership collaboration with Tabor Group and LDTF/HSE in fostering SMART Recovery Peer led groups in the Region to generate a Recovery Social Support Network in addition to 12 Step Fellowship.

More communication and integration with other addiction services. Better communication to their service users about what is required with their aftercare. Printing care plan on a page is not sufficient. Getting to know people who work with their service users in the community and not just having us as a service they know little about.

I think there should be review of the continuity between the 28 day prog and the secondary treatment. That Tabor group liaise with community projects more, and support service users to make contact with community supports before the 28 day prog or the sec prog have finished. Do a review with service users about how they feel about the payment for a/c and womens day. Review the structure and management of the CE schemes . A few years ago, CE workers were docked money when they attended a SAOL womens day event in Dub , and the women at the time, discussed how they were docked money when they met with their social workers, or even when they attended access with their kids. I would like to see a review of the CE scheme and how it;'s being used to support people in recovery. From what i see I think that Tabor remain disconnected from other services when it comes to looking at a holistic care plan with service users . From my knowledge of treatment centres, and the client group that I work with, I think it would be useful for clients, if there was a stronger connection made with social work in particular. I find that for parents with kids in care, there are complex needs around supporting parenting, when they only see their kids in access , and working with Social work so that SW

I would like to receive confirmation of admission of our client. I believe a Telephone conversation between the referring counselor and the clients counselor in Tabor Lodge could be very beneficial to treatment process as the client may have worked with us over a few years. I would like Tabor Group to have enough funding to provide continuing care in either Fellowship or Renewal if necessary as this can be a major block to some clients who need more than 28/30 day treatment.

A better care/planning approach. More realistic care plans Workers roles within the care plans properly identified and names given for specific roles (I recently had a client with a care plan that said to engage with 'the link worker' yet no name was given and the client did not know who the link worker was. I had to find out the information for the client.

Tabor Lodge and secondary treatment work closer together, as in individual cases, if primary treatment counsellors recommend that a person go to secondary treatment, that tabor Lodge arrange this with the secondary treatment centre and bridge the gap where people have unstable or accommodation to go to in between.

For facilitators or key workers be available to attend care plan meetings Clarity of roles in joint care plans- case manager to remain with the primary agency- Tabor Lodge group - if client in programme with Tabor Lodge group

APPENDIX 2: ONLINE ANONYMOUS SUBMISSIONS (GROUP 2: STAFF, BOARD MEMBERS AND KEY-INFORMANTS)

With your overall experience of working with Tabor Group what in your experience works? (max 400-500 words)

My job is done well and to best of abilities but when am I told this?

For some clients the MM works but not all. The work experience in secondary treatment has potential but not followed through in terms of actual experiences. Many clients would benefit from life-skill training e.g. cooking, budgeting.

I'm on the board and don't work directly with the group. However I do refer patients to the group and am very impressed by how the treatment transforms some people's lives so positively. I'm also impressed with the professionalism of the people I've had most dealings with - the clinical director and General Manager. They care. I've never been on a board before but I can see that the other board members care also. And they are all really competent in their own areas.

The standard of counseling seems to be very effective. Accreditation and compliance works very well

The reputation of Tabor Group and the high occupancy levels at all centres is impressive. As a Board Member for only the last 15 months my experience of the services offered is limited although I have spent a number of days in all locations.

The specialist treatment given across the three centers has been working well to date. In light of changing causes of addictions - especially with cross addiction - the clinical evaluation been conducted is necessary to ensure that the treatment for the addictions are in line with international standards and best practice. The development of a very high level Strategic Plan is essential and an updated review of this plan will be required in light of the forthcoming treatment evaluation. The service of treatment will need to change as much as the facilities and a state of the art location and building for the main residential center is of paramount importance in the future delivery of treatments. The family treatment is proving most beneficial but requires further funding to expand its services.

I believe the organisation is very client centred, and that clients are treated respectfully and with great compassion. I believe the principle of total abstinence as a primary goal of treatment serves most clients well and I believe that in relation to this. I think clients are set-up with many supports, post-treatment, to help them in their pursuit of abstinence if this is what they wish. I believe the involvement of family works very well in the input it provides to a clients treatment and the support that family members receive as clients themselves.

With your overall experience of working with Tabor Group what in your experience does not work? (max 400-500 words)

management tell rather than share....what happened to yearly job review? If i make mistake immediately blamed/criticized.

My role and work not appreciated...I have no sense that others appreciate or understand work I do and issues we deal with at my low level.... Job title does not reflect actual work or experience... Lack of clarity on basic things. I had no real instruction when I joined. I felt lost and totally out of place. Now I see I have a role but it shouldn't have taken so long the board should know more about what actually goes on.

Administration and management across all 3 centres appears to be inefficient. I'm not sure if the high level of part time staff works well or not.

I believe the executive and management is under resourced and clinical type people are therefore obliged to spend a large portion of their time on admin type functions. Relationships between senior personnel are - to my recent knowledge - strained. The imminent retirement of the General Manager - with no internal person capable of acting for her- poses a huge risk until a new CEO is appointed. A revised management structure is required which will minimise risk during staff absences is required. The lack of a Governance Code - although this is now being belatedly addressed by the Board - is a very serious shortcoming. Better synergies in both clinical and admin areas between Tabor, Renewal and Fellowship needs to be encouraged.

The support from the local stakeholders regarding funding is greatly appreciated, but the lack of support from the Government at National Level, falls well short of what is required. More work and funds are required at National level to support people who are seriously ill with addiction illness and mental illness, There has been very little analysis carried out on the costs of addiction treatments compared to medical costs of addictions coupled with the assistance given to families of addicts.

I believe counselling staff are working under a lot of stress. The needs of clients have become increasingly complex and has resulted in an increasing workload for counsellors. While Tabor Group has embraced the idea of meeting the more complex needs of clients, I don't believe that the treatment team has been sufficiently resourced to cope with the extra workload involved. It is great that Tabor Group has remained so client-centred, however I believe that staff welfare, in particular the welfare of the counselling team, often comes second place. As things are currently, I believe that the increased workload for counsellors and lack of additional resources has had a negative impact on staff morale and this no doubt has an impact on the quality of service for clients. I believe that the treatment programme in Tabor Lodge in its traditional form often tries to achieve too much with clients who present with very complex needs and minimal resources/supports. I believe the traditional Minnesota-model understanding of addiction being a disease is too reductionist, outdated and not in line with modern research and developments in the field of mental health, and counselling/psychotherapy. It is very unfortunate that there is not a streamlined transition for clients from Tabor Lodge to Fellowship House and Renewal. It seems cumbersome that clients have to be reassessed and charged a fee when accessing services provided by the same organisation.

What changes would you like to see happen within Tabor Group? (max 400-500 words)

Better pay and holidays

Better communication between staff. On-going training open to support workers to move onto Counselling roles. In my role counselling-like skills are required yet no training in all my years from TG. It seems to me that we only to training that TG obliged to provide e.g. First Aid, Fire Training. I have been in same role since start nearly 20 years ago. Any previous skills (and, there were many!) have been lost - at cost to both myself and TG. My role is not appreciated and one example is the poor wage... Incremental pay to reflect experiences I work full-time yet only get max 15 shifts off a year - including usual have to save 6 for Festive season when TG close... When move occurs (FH) will have more clients but no communication or input into this... Yet, I imagine workload will increase without pay or job title to reflect extra work and stresses.... Clients seem to have more info on move and daily happenings than I do...

Greater integration with other relevant agencies

Tabor Lodge to be a state of the art facility and an organisational restructure to make management and staffing more effective and efficient.

As stated above, change the treatment model in line with best practices elsewhere and update some of the facilities. More financial assistance to enable Tabor Group to expand its services and facilities.

I would like to see additional counselling staff involved in the delivery of the treatment programme. Counsellors are extremely busy in the delivery of the treatment programme as it currently stands and I'm not sure that this effort equates necessarily to better client care. I would like to see Tabor Group having a greater integration with external agencies/services, especially with mental health services. I would like to see Tabor Group broaden its understanding of the interplay of trauma, addiction and mental illness and to deliver a more holistic treatment on this basis. I would like to see a more intensive continuing care service available to clients with more complex needs (1-to-1 counselling)



TABOR
GROUP



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



CLDATF
Cork Local Drug & Alcohol Task Force



SRDATF
southern regional drug & alcohol task force

An Evaluation of Tabor Group.

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