



# **SUBSTANCE MISUSE ISSUES IN DUBLIN'S NORTH EAST INNER CITY**

## **A Community-based Needs Analysis**

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***‘There is a real opportunity to do something significant despite it  
being a huge challenge’***

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It should be noted that the views expressed in this study are those of the participants and the authors and do not necessarily reflect the views of the NIC DATF and/or the Department of Health.

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## 1.0 INTRODUCTION

As a response to a spate of drug related shootings resulting in a number of deaths in the North East Inner City (NEIC) of Dublin, the Irish Government commissioned a report on an appropriate response. The Mulvey report was published in 2017 (Mulvey 2017). The origins of the report emerged from a community which had experienced multiple violent acts arising from extreme criminal activity linked to drugs. Many of these murders took place during daylight hours while people were going about their everyday lives.

Part of an action plan recommended in the Mulvey Report was the creation of an integrated system of social services so that services would work well together, and that communities and providers are aware of what is available and how to access such services while focussing on services that can be flexible in response to the demands of local needs. Specifically, in relation to substance misuse that support, treatment and rehabilitation services should respond to identified need.

One of the outcomes of the Mulvey report was the establishment of a Programme Implementation Board (PIB). This Board consisted of a number of structures to ensure that there would be direct links between dedicated implementation of the recommendations, informed by the work of other groups and sub-committees. The PIB includes representatives from Dublin City Council, An Garda Síochana, and the Departments of the Taoiseach, Health, Social Protection, Education, Children and Youth Affairs and the HSE as well as relevant business representatives.

The PIB established a substance use/misuse group to identify and implement improvements in addiction treatment and rehabilitation services. These services are being developed to provide an integrated model of care for service users with complex needs, including poly drug use, mental health issues, entrenched homelessness and social isolation. This needs analysis is a contribution to that objective.

This approach underpins a general recognition that supporting community-based organisations is an effective manner in which to link research to action. The Health Research Board (HRB) has recently proposed a strategy of community-based knowledge transfer and exchange in order to facilitate research evidence in service planning and delivery in work on substance use in Ireland (HRB 2018).

This Needs Analysis on substance misuse was commissioned by the North Inner City Drugs and Alcohol Task Force (NIC DATF) to inform its contribution to the NEIC initiative. It is a community-based analysis which is informed by the opinions of the people who are experiencing substance use issues and either engaged or not engaged with services, families who have a member with a substance use issue, their community representatives as well as by those tasked with service provision and overseeing change.

## 2.0 OVERVIEW OF SUBSTANCE MISUSE

### 2.1 Substance Misuse in Ireland

There is considerable documentation on the use of illicit substances and the effects they have on individuals, families and communities. Estimating prevalence (a measure of how many substance users exist in any given area) is fraught with difficulty as substance users are generally a hidden population by virtue of the illegal nature of their substance use activity. Typically, data collection for prevalence will use a number of routine data sources such as criminal justice, drug treatment, mortality and morbidity. However, even using all of these sources does not give an accurate picture of true substance use prevalence, as many users will not be accessing treatment and may never have come to the attention of the criminal justice system (NACD 2003). Substance misuse is generally more common in males than females, and more common among younger age groups (EMCDDA 2018).

The most frequently used forms of substances in Ireland include opiates (including heroin, methadone, morphine, codeine, fentanyl), MDMA/ecstasy, NPS (new psychoactive substances) and cocaine, with cannabis remaining the most commonly used illicit drug (EMCDDA 2018). And while prevalence is not fixed, there is substantial data to suggest that substance misuse has increased among the general adult population in recent years (EMCDDA 2018).

Substance misuse has increased year on year in Ireland since the first population surveys began in 2002. The most recent total population survey of drug use indicates that 31% of people between the ages of 14 and 64 years have used illicit drugs in their lifetime – a rise of 13% since 2002 (NACDA 2015).

### 2.2 Socio-Economic Overview of the NEIC Area

The strong link between substance misuse and social and economic deprivation was first highlighted as part of Irish Government Policy in the mid-90s with the establishment of a Ministerial Task Force on measures to reduce deprivation and so design strategies to reduce the demand for drugs in at-risk areas (Task Force 1996). The North East Inner City (NEIC) continues to be an area experiencing high levels of social and economic deprivation.

#### 2.2a Deprivation

As part of one of the most disadvantaged areas of Dublin City, Dublin Inner City contains significant clusters of high deprivation of which the North East Inner City (NEIC) has historically had the highest relative deprivation score (Trutz Haase 2009).

The NEIC area has a total population of 20,112 people, of which 6.2% are aged 65 years and older (n=1,256), while 4.7% of children are aged 4 and under (n=953) (CSO 2016).

#### 2.2b Family Structures

The rate of lone parents, while increasing generally in Ireland over the past 20 years from a national rate of nearly eleven per cent to just over twenty-one per cent is considerably higher in Dublin. In Dublin Inner City every second household is headed up by a single parent (50%) while the number of single parent households in the NEIC area is the highest at 55% (CSO 2016).

#### 2.2c Education and Employment

Rates of education again are lowest in the NEIC with more than 21% of people completing primary school education only and similarly, the lowest percentage of people who complete tertiary education at 38% (CSO 2016). Female unemployment in the NEIC stands at 19% and male unemployment at 24% (NEIC 2017).



## 2.2d Housing

While owner occupied housing has fallen in Dublin overall from 69.7% to 67.6% in the period 2011 to 2016, the percentage of owner-occupied housing in the NEIC is considerably lower than the city average. In the most deprived areas of the NEIC, owner occupier rates fall to between 6.8% and 16% and over the four most disadvantaged areas (by electoral division) only stands at an average of 19.2%. There is a total of 7,002 households in the NEIC area, with some 68.7% of residents in NEIC living in rented accommodation (CSO 2016).

## 2.3 Overview of Substance Misuse Services in Ireland

Ireland's 'Misuse of Drugs Act' was first enacted in 1977, but it was not until the mid-80s, with the advent of the first 'heroin epidemic' (when injecting heroin use became an issue in Dublin) that there was recognition of the problems associated with substance misuse (Dean et al 1985). The response at the time was to establish the National Drug Advisory and Treatment Centre in what was then Jervis Street Hospital in Dublin. In addition, Coolmine Therapeutic Community was another option for substance misuse as well as an in-patient unit in St. Brendan's Psychiatric Hospital. However, both facilities focussed on the aim of people becoming drug-free (an abstinence based model) and that in order to do so, they needed to be hospitalised and therefore community services had no role to play in this process (Butler 2016).

This changed with the advent of the newly discovered virus, HIV, which was prevalent in injecting heroin users in the 1980s and 1990s alongside the second 'heroin epidemic' (O'Gorman 1998). Interventions started to focus on 'harm reduction' and so the introduction of Methadone Maintenance Treatment (MMT) as a way of managing this. MMT is a widely used opioid substitution treatment (OST) in a number of countries. To provide MMT a number of small 'satellite clinics' were set up by the then EHB (Eastern Health Board). Alongside this development, reducing drug supply became an issue and laws were introduced which allowed for the establishment of specialised police forces within the Garda Síochána as well as new laws introduced to tackle organised crime (EMCDDA 2016).

The rapid growth of the drug problem, located in deprived areas in Dublin's Inner City and the Government's apparent lack of rapid response to a large number of drug deaths led to the communities in these areas taking to the streets to protest. This had the effect of forcing the Government to act at a local level in the development of a response while policy endorsement came considerably later on in the process (EMCDDA 2016).

## 2.4 Alcohol and Drug Misuse in Ireland

### 2.4a Alcohol Misuse

Meanwhile, issues around alcohol misuse began to emerge as a very real problem in Ireland, remaining at high levels in spite of increased levels of duty on alcohol and the advent of the recession in the 2000's. Alcohol consumption studies indicate that 1.35 million people in Ireland are 'harmful' drinkers, with a further 150,000 people classed as 'dependent drinkers' (HRB 2016). Harmful drinking leads to three alcohol related deaths each day (Mongan 2016). Alcohol misuse is linked to a variety of medical conditions, road traffic accidents, poor mental health and suicide (HRB 2014).

Recent figures suggest that while alcohol consumption remains at very high levels, drinking until drunk (binge drinking) is of particular concern as a major driver of alcohol harm. Binge drinking is common place and Ireland has the second highest rate of binge drinking in the world. These figures show that 75% of alcohol consumed in Ireland is done so as part of binge drinking and also that binge drinking is more likely to occur in younger age groups as well as in areas of social deprivation (HRB 2018).

#### 2.4b Substance Misuse

The first National Drugs Strategy was put in place in 2001 and made no mention of alcohol as a substance misuse issue (Department of Health 2001). This Strategy document was superseded by the 2009 strategy which focussed on prevention, supply reduction and rehabilitation, and was the first time that drugs and alcohol as substance misuse issues were linked in a strategic way. However, this policy effectively moved alcohol treatment from mental health services to Primary Care Addiction Services (Department of Health 2009). The most recent strategy document recognises the health and social problems of drug and alcohol misuse and responses to both issues are central to the strategy (Department of Health 2017).

Drug Policy today is part of the remit of the Social Inclusion of the Health Service Executive, reflecting a shift from seeing substance misuse (drugs and alcohol) as purely a criminal justice issue to a recognition that those caught in a cycle of substance misuse need a comprehensive range of services for them to live full, independent and meaningful lives (Mayock, Butler and Hoey 2018).

The current policy document from the Department of Health has moved more towards a health-led response to drug and alcohol misuse. It aims to reduce risk factors for substance misuse which include social and educational disadvantage as well as family and health factors. The stated vision is:

*‘A healthier and safer Ireland where public health and safety is protected, and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and well being and quality of life.’*

(Department of Health 2017 pp8).

To achieve this, the strategy has five main goals which include the promotion of health, prevention and education as well and the minimisation of harms around substance misuse and addresses the harm of drug markets and in doing so supports the *‘participation of individuals families and communities.’* (Department of Health 2017).



## 2.5 Substance Misuse and Associated Personal and Social Issues

There are a number of harms associated with drug and alcohol misuse, both on a personal and social level.

### 2.5a Personal Issues in Substance Misuse

### 2.5b Substance Misuse and Health

#### 2.5b (i) Physical Health

The short term effects of substance misuse (regardless of the substance used) can lead to a number of health and mental health issues, and in some instances death. The long term misuse of substances (both drugs and alcohol) can lead to long term illnesses including heart and lung disease, cancer, mental ill health, HIV/AIDS and hepatitis (HRB 2014).

#### 2.5b (ii) Mental Health

As well as major physical health problems, long term substance misuse is often accompanied by poor mental health, most noticeably depression and anxiety. Recent findings in an Irish context indicate that many people presenting for treatment of alcohol and/or substance misuse have high levels of mental ill health. In one tertiary addiction centre in Dublin, 43% of 137 patients had a mental health disorder the most common of which was depression (at 53%) (Iro and O'Connor 2009). Further studies indicate that there are high levels of mental illness in those using both cocaine and alcohol (45.9%) reducing to 37.2% where alcohol was the only substance misuse and yet another study indicating that those with alcohol only as their substance met the criteria for depressive disorder in 25.3% of cases (Lyne, O'Donoghue, Clancy and O'Gara 2011; Lyne, O'Donoghue, Clancy, Kinsella and O'Gara 2010). In a study of people with schizophrenia, 39% fulfilled the diagnostic criteria required for a lifetime history of substance misuse, the main substances being alcohol and cannabis. (Kamali, Kelly, Gervin et al.2005).

The strategy 'A Vision for Change' was the first major policy document published which focussed on the improvement of mental health services in Ireland (HSE 2006). Under a section entitled 'Special Categories of Service Provision' the strategy outlines the approach to those with 'co-morbid severe mental illness and substance abuse problems.' It places the majority of the responsibility for care of people with addiction issues outside the mental health system but notes that community mental health services should respond to the needs of people with both addiction and serious mental health disorders. The document states that service users with both problems would be assessed by adult CMHTs (Community Mental Health Teams) to provide a care plan which involves both counselling expertise and mental health intervention. The strategy notes that 'mental disorders' are almost three times as common among those with alcohol dependence compared to the general population and that 40% of service users, managed by CMHTs, reported drug or alcohol misuse problems.

Dual diagnosis is a term that is generally accepted to mean the diagnosis of a service user presenting with both addiction and mental health issues. There is recognition that, especially with severe mental ill health, there is need for a greater level of service utilisation as well as more reliance on in-patient treatment and that generally outcomes are poorer (Mc Gabhann, Scheele, Dunner et al 2004).

A report on the dual diagnosis issue found that there was a need for much closer collaboration between addiction programmes and general mental health services to improve these outcomes, and that overall such cases responded well to case management and the use of multi-professional teams. Specifically, the strategy recognised a need for the development of specialist teams that should establish clear links with local community mental health services (HSE 2006).

However, in the light of reduced spending on mental health during the economic recession in Ireland, many of the goals in the Vision for Change strategy were not achieved. A review of the strategy, ten years later, reiterated that the major responsibility for care of people with addiction issues (both substance and alcohol misuse) lay outside of the mental health services, and urged much closer working relationships to meet the needs of dual diagnosis. A review of the original strategy found that specialist community teams, which were to address the complexity of substance misuse and mental health had not been developed (Mental Health Reform 2015).

A more recent approach to community supports in the area of mental health is the recruitment of 'peer support workers' who form part of multi-disciplinary teams in various mental health services. These are trained peer workers who have experienced mental health issues themselves and use their personal knowledge, when appropriate, to help improve the lives of those struggling with mental health difficulties (HSE 2018).

#### 2.5c Social Issues in Substance Misuse

There are a number of social 'harms' that are associated with substance misuse and the issue of substance misuse is now recognised as one which does not just impact on the individual in terms of their health, but also leads to problems with housing, employment and social exclusion. Additionally, there is a recognition that substance misuse harms do not occur in a vacuum, rather that they create a ripple effect of harm throughout the family and community in which the substance user is situated (Capello et al 2006; Duggan 2007; Orford et al 2007; Schafer 2011; Stewart et al 2007). Although there is evidence of a lower level of substance misuse in women than in men, these harms are evident for both genders (Van Etten ML, Anthony JC. 2001). As a result, there is a need to treat substance misuse not just as a problem for the individual, regardless of gender, but to approach it as part of a set of complex problems experienced by the individual, their family and the community in which they live.

##### 2.5c (i) Family Disruption

Substance misuse is strongly linked to disruption in family relationships. This disruption can affect the wider family with many experiencing feelings of isolation, abandonment and guilt when they decide to cut ties with the individual substance user. Some family members may feel the need for protection from the individual. Several studies indicate that living with a relative who is experiencing substance misuse is extremely stressful for family members who can experience harassment, the fear of violence or actual violence, psychological abuse, property theft, debts, loss of income and homelessness. Death from substance misuse can leave other relatives caring for young children with little or no financial support as well as additional debts (funeral costs, drug debts) at a time of great personal loss. (Copello et al 2010; Duggan 2007; Orford et al 2010; Rossow and Hauge 2004; Schafer 2011 cited in McDonagh and Reidy 2015).

This stress has a ripple effect on family members, with an estimate that every one substance user in the family will have a significant impact on the physical and or mental health of two further family members (Duggan 2007).

Within the nuclear family, difficulties arise around the parent/child relationship, with many children of two parent families becoming the 'surrogate partner' for the parent who has a substance misuse issue. In single parent families often children become the 'care-giver' for the family, especially where there are younger siblings. For older parents with adult children who are caught in substance misuse, a co-dependent relationship can evolve where the adult child fails to move on in their own life to become independent (SAMHSA 2004).

In particular, children who are brought up in an environment of substance misuse are more at risk of abuse and neglect as substance misuse often diminishes parenting capacity, especially where there is no other support from family or services as a result of disruption of extended family relationships. Additionally, they are more likely to go on to develop problem substance use issues themselves (McDonagh and Reddy 2015). Recent studies by the local Drugs and Alcohol Task Force on the views of young people on drugs and alcohol issues in the NEIC area has called for the inclusion of their voice in the development of future National Substance Misuse strategies (NIC DATF 2018) and on future prevention and education and training programmes (NIC DATF 2014).

#### *2.5c (ii) Communities*

It is widely accepted that substance misuse is linked with crime. In the first instance, the effects of alcohol and violence are well established as is the fact that 'economic compulsive' crimes tend to occur when those caught up in substance misuse commit criminal offences in order to generate income to pay for substances. Drug distribution lends itself to what has been termed 'systemic drug related crime' which includes fights over territorial and organisational issues as well as disputes over transactions and drug debt. The rising availability of guns in Ireland (often imported with drugs) has led to increasing numbers of homicides as a result of 'gang wars' over such disputes (Connolly and Buckley 2016).

Research on drug debt and its impact on areas such as the North Inner City and Limerick ((Connolly 2003; Hourigan 2011; NEIC 2018) indicates that residents lived in fear and were unlikely to report threats for fear of reprisal which could come in the form of physical assault as well as threats and damage to property not just of the person owing the debt, but also to the wider family. Families, or individuals, trying to pay such debts were often on low incomes and given short re-payment periods and so had to resort to loans from both mainstream sources as well as money lenders or, in some instances, re-mortgage their homes. Those with substance misuse issues themselves were forced into criminal activity to pay off their debt which may have occurred either as a result of an inability to pay for drugs for personal use or, in some instances, where drugs were seized by Gardaí. In many instances, the debtors were forced to become involved in dealing, transporting or storing drugs, performing acts of violence for sellers or being forced into sex work. The Limerick study pointed to a 'code on the street' leading to certain people being identified as those to be most feared thus ensuring that reporting to the Gardaí was very limited (Connolly 2003; Hourigan 2011).

Open drug markets, generally, have an ongoing impact on communities leading people to restrict their movements and engage less in social participation and creates the loss of a communal space where people feel free to meet. Such fear and intimidation as a consequence of the development of drug markets in specific areas has both an 'insidious and disproportionate' impact on that area (Connolly and Donovan 2014).

### *2.5c (iii) Housing and Homelessness*

Homelessness in Dublin has increased year on year, with a number of contributing factors including increased market rent, changes in the Rent Supplement System (RAS, replaced by the Housing Assistance Payment HAP), overall reduction in budgets for social housing (from €1.7bn in 2008 to €597m in 2014) and legislation introduced in 2013 which banned the rental of bed-sits. In spite of additional capacity, emergency beds for the homeless population in Dublin are filled each night (Glynn 2016). A trend of major concern is the amount of families that have presented as homeless, either as a result of losing their home due to rent increases or as a result of a lack of affordable housing (Focus Ireland 2018).

With the need for a focus on family homelessness, and in particular taking children out of homeless services and into permanent homes, there is less of an imperative in policy circles to look after other vulnerable populations.

However, another cohort experiencing increases in homelessness is that of those with substance misuse issues, and the proportion of those who had become homeless as a result of an addiction issue rose from 23.7% in 1997 to 37.9% in 2013. The proportion of people in homeless services who reported drug use (of any kind) rose from just a third (29%) in 1997 to 80% by 2013. These figures suggest that substance misuse can in some instances lead to homelessness and equally that there are much higher numbers of people with substance misuse issues accessing homeless accommodation than at any time in the past (Glynn 2016). A substantial number of people who are homeless are so as a direct result of addiction, and recent figures suggest that this is linked to an increase (49%) in deliberate self-harm and drug related deaths (Glynn et al. 2017).

There is a concern that the reverse also happens – that people in unsuitable homeless services (hostel type accommodation) become involved in drugs and alcohol for the first time (Merchant's Quay Ireland 2017). Equally there is evidence to suggest even for people on long term MMT programmes, who can be quite stable, homelessness triggers an increase in chaotic drug use and increased methadone dosages (Mayock, Butler and Hoey 2018). A recent Government initiative is focussing on a 'Housing First' model for those with complex health needs, including those in addiction (HSE 2018). Additionally, the HSE is currently undertaking an integrated approach to addiction and homeless services in the HSE (See Appendix 1).

## *2.6 Recovery*

Moving from the historical model of abstinence, policy makers recognise that substance misuse is often a chronic relapsing condition and, as such, that 'recovery' is a journey, with rehabilitation as the process which should support and encourage the individual at each stage on that journey. This strategy acknowledges that 'recovery' means different things to different people – that for one, overcoming dependence for the primary drug use may be their aim of recovery while for others, abstinence is the goal (Department of Health 2017).

There is also the recognition of the need to establish 'recovery capital'. It is generally accepted that there are four components to recovery capital – social capital (family memberships and ties), physical capital (housing, employment), human capital (skills, health) and cultural capital (linked to social integration) (Cloud and Granfield 2008).

The HSE has proposed a 'continuum of care model' based on access to the supports needed for individuals experiencing substance misuse to attain personal recovery goals (Bryant-Jefferies 2004). These interventions include at an initial level information, advice and referral interventions, where

the main focus is not on drug treatment but on social care in the form of family, housing, educational, criminal justice and general healthcare supports.

The second tier focusses on drug-related interventions whether they be community based, outreach or part of specialist addiction services. Specialist interventions at the third tier focus on interventions in a prison, hospital or community setting while the final tier focusses on specialist dedicated inpatient or residential detoxification places (Department of Health 2017).

This approach reflects the need for key working and case management in order to develop an 'integrated care pathway' which is the shared responsibility of a range of State, NGO (Non-Governmental Agencies), Community and Voluntary Agencies as well as communities, families and the individual presenting with the substance misuse issue.

*'No one service can cater for the diverse needs of the service user.'*

(Department of Health 2017 pp34).

## 2.7 Research Aims and Objectives

A recent report on the estimates of problem opiate use in Ireland by the Health Research Board (HRB 2018) notes that supporting community-based organisations' use of evidence is an effective way in which to link research to action in health programmes. This needs analysis is one such approach in which the knowledge and experiences of the community and service user (or prospective service user) can potentially be used to facilitate service planning and delivery.

The overall aim of the research was as follows:

To assess the needs of people involved in substance use issues in the North East Inner City.

In order to achieve this, a needs analysis was conducted to ascertain the views of people both living and working in the NEIC who have a direct involvement in substance misuse, either in a professional capacity (as service providers, policy makers and community representatives) or at a personal level (people in addiction and their families).



## 3.0 METHODOLOGY

### 3.1 Research Aims and Objectives

The model of care proposed by the HSE in their most recent strategy document requires a high level of investment both financially and in terms of resources. As a National Strategy Document the policies described in it are intended to respond to the needs of substance (drug and alcohol) users throughout the country (Department of Health 2017). The North East Inner City (NEIC), which has always experienced economic and social deprivation, was the first area in the country to experience the problems of the first and second 'heroin epidemics' and the community response served as a catalyst for a Government response in terms of policy and services. As such, the NEIC and its people (those with substance use issues, families, community representatives and service providers) are well placed to assess the current configuration of policy and services in its own area, and this research study was designed to achieve that aim.

The overall aim of this Needs Analysis Research was as follows:

To assess the needs of people involved in Substance Use Issues in the North East Inner City.

Specifically, the research objectives were:

- (a) To obtain the views of service users with substance use issues on gaps in the current configuration of services;
- (b) To obtain the views of substance users who were not engaged in services
- (c) To obtain the views of a and b above on the overall response to the substance use issues in NEIC
- (d) To obtain the views of service providers, community representatives and policy makers on the effectiveness of current policy and practice.
- (e) Based on a to d above to make recommendations for change.

### 3.2 Needs Analysis Study Design

In order to assess these needs successfully, the best practice was to take a qualitative approach to data collection. This approach was deemed most appropriate as it allowed for a broader and less restrictive concept of research design in that it could be interactive and respond to additional issues that the participants might broach in interview (Becker, Geer, Hughes and Strauss 1961; Frederick et al 1993; Maxwell 2008; Yin 1994) and in this way could use an emerging approach to inquiry with the final report including the voice of the participants (Maxwell 2008).

A qualitative approach also meant that research could focus on phenomena in a natural setting to understand how people manage their day-to-day situations (Miles and Huberman 1994).

Specifically, in qualitative substance misuse research, qualitative data gathering is used to enable participants to describe the social meanings and processes of their substance use and allows for a focus on the details of participants lived experiences (Rhodes 2000).

This approach was best suited to the nature of this study – that of the individual experiences of an issue affecting the lived experiences of the people involved with substance issues in the NEIC and reflected the embedded nature of the original Mulvey Report, which was conducted over a number of months in the NEIC area (Mulvey 2017). Ascertaining the views of service users is part of the National Drug and Alcohol Strategy Document (Department of Health 2017), which focusses on encouraging people in receipt of services to be involved in the planning and delivery of those services.

### 3.3 Data Collection

In order to achieve the research objectives, data collection was divided into two main areas:

Group A	Input from service providers, community representatives and policy makers working in the NEIC area.
Group B	Input from substance misusers and their families – either engaged in services or not engaged in services who are living in the NEIC area.

#### 3.3a Data Collection Group A

A combination of one-to-one and focus group interviews were drawn up for this group:

One-to-one or focus group interviews with service providers in the NEIC area targeting specific cohorts (single parents, young people, non-engaged service users, family support)

Focus group interviews with Community Representatives, any Working Groups and Advisory Committees.

It was envisaged that 13 to 15 participants would be sought for Group A. However, due to large attendance at one working group, the final number for Group A was 34 in a series of one-to-one, small and large focus group interviews.

#### 3.3b Data Collection Group B

A combination of one-to-one and focus group interviews were drawn up for this group:

One-to-one or focus group interviews with service users (both engaged in services and not engaged in services) and individuals with a family member who was either (at the time of the study) experiencing substance misuse issues or had in the past.

The study aimed to gain access to between 16 and 24 participants in Group B. Due to some difficulty in gaining access to non-service users for a number of reasons (outlined in Section 3.7), the lower end of this number (18) were interviewed for the study.

### 3.4 Data Collection Methods

The most effective method for data collection in both groups was that of a short one-to-one semi-structured, open-ended interview or a focus group when participants agreed to this. For Group B, a sample was drawn up that reflected the specific demographic of the NEIC area which has a high level of single parent families as well as those experiencing housing insecurity and those not engaged in services as well as families who had a member experiencing a substance use issue.

The combination of Groups A and B meant that the majority of the needs analysis was informed by people with substance use issues and their families – both of whom were normally resident in the NEIC area and therefore giving an insight into their lived experience. Other input (from community representatives, service providers and senior stakeholders) would reflect the experiences of those working, but not necessarily living, in the NEIC area.

#### 3.4a Interview Schedule

For Group A, senior stakeholders and community representatives were asked for an overview of what they felt were the major issues facing people in the NEIC area around substance misuse. Service providers were asked for a brief background on the services they provided. All were asked what they felt were the gaps in services and also their understanding of recovery and moving forward.

For Group B, all participants were asked for a brief background (age, education, employment, housing, family structure) as well any issues around service provision and engagement, either for themselves or their family member. Additionally, those with a substance use issue were asked about their drug or alcohol use (age of initiation, type of substance) and their current substance use.

#### 3.4b Gatekeepers

Gatekeepers were enlisted to help with engaging participants from Group B. The use of Gatekeepers was critical for this research for a number of reasons – not only to provide access to a difficult to reach population, but also to be involved in making decisions as to the capacity or otherwise of potential participants to competently make decisions about their consent to participate in the research (Bulmer 2001).

The Gatekeepers are service providers who work with individuals who experience substance use issues on a daily basis as well as with their families and have a good knowledge of the capacity of the individuals with whom they work and the difficulties facing them.

### 3.5 Data Analysis

In total, 52 interviews were conducted over the period November 2018 to February 2019. From Group A, 34 participants took part in the research and 18 from Group B.

Interviews from Group A typically lasted on average 38 minutes in instances of one-to-one, while focus group interviews typically had a duration of 55 minutes. The majority of these interviews were conducted at their places of work, with just one taking place in a coffee shop. All participants consented to audio recording. One participant could not attend a focus group interview and opted to email a response to the interview questions.

Interviews from Group B for family members typically lasted on average 47 minutes, either as a one-to-one or in a focus group. Both of the focus group interviews were facilitated by the service provider in situ. Two interviews took place in the family home. One participant refused audio consent and that interview was taken in shorthand and terminated after 15 minutes at the participant's request.

Interviews with service and non-service users in Group B lasted on average 48 minutes for the focus groups, 10 minutes for the non-service users, and 20 minutes for the service users. All participants consented to audio recording.

The interview recordings were transcribed verbatim and any identifying features were removed so that anonymity could be assured. The transcripts were assigned alpha-numeric codes and pseudonyms were assigned. In some instances (n=4) participants who were in direct service provision were also part of a working group. As their role was different in each case, they were assigned two separate codes and identities to protect anonymity. For the purposes of this study, they are given a pseudonym and in the instance of service providers and senior stakeholders are referred to by this pseudonym and a description of the agency type (Statutory, NGO, Cross Section or Community/Voluntary), while the Community Representative Group participants are referred to by pseudonym and role. Given the small geographic area of the NEIC, pseudonyms as well as age ranges were assigned to participants in Group B to further ensure anonymity.

These were then coded and analysed incrementally using NVivo, a data management software package. This allowed for the data to be structured into emerging themes which could then be used for analysis.

### 3.6 Ethical and Other Considerations

Ethical approval for the Needs Analysis research was granted by the Ethics Committee of Trinity College Dublin on 9<sup>th</sup> November 2018.

As discussed above all potentially identifiable references were removed from the transcripts and an alpha-numeric code and pseudonyms were assigned to participants. Additionally, when quotes are used in this report, an age range is given instead of a specific age which could also act as an identifier given the small geographic spread of the NEIC.

Participants from Group B are often considered representative of a vulnerable group in society. A vulnerable group is defined as a number of people who share social characteristics that place them at a higher risk of poverty and social exclusion than the general population (Frohlich and Potvin 2008). However, care was taken to ensure that they had the capacity to give informed consent and that they understood that their participation bore no relation to their access to services at the time of the study or in the future. While there is considerable debate about substance users being regarded as a vulnerable population (Aldridge and Charles, 2008; Seddon, 2005; Souleymanove 2016) there is also a comprehensive body of research which considers participation in research as a positive empowering experience (Richards and Schwartz 2002; Sutton et al 2003; Ulin, Robinson and Tolley 2005). Participants were also reassured that they could change their mind at any time, refuse to answer any questions put to them and decline to be audio-recorded. Although there are concerns with the potential for social control in such research (Broadhead 1976) every effort was made to assure participants that their access to services would not be impacted by their decision whether or not to participate or even withdraw at any time.

The researcher contacted the Gatekeepers by email initially and followed up by phone. They were made aware (by way of a detailed information sheet) of what exactly was required of the participants in terms of the overall aims of the needs analysis, the interview schedule and the consent. On their agreement to participate and recruit service users, the Gatekeepers were given a number of weeks to recruit participants, allowing time for the participants to make a decision as to their involvement. A date and time of meeting suitable to the participant was set up and the consent form and study aims were read to the participants at time of interview. They were again reassured that they could change their mind at any time. To avoid over recruitment, four Gatekeepers were initially contacted. Only if and when they decided not to engage with the research was another Gatekeeper approached.

Data (audio recording and transcripts) were held on a password protected computer and stored using an encryption software (Microsoft BitLocker). Consent forms were stored in a locked file cabinet. All data is held by the NIC DATF, who commissioned the study, for a period of five years after which it will be destroyed.

A token payment (in the form of a €20 voucher for an Irish supermarket chain) was given to the participants from Group B as a way of thanking them for their time. They were not notified in advance that they would be receiving any gift and so the payment was not designed to act as an incentive to participate and the sum bore minimal implications, in ethical terms, for recruitment and consent (Head 2009).

### 3.7 Inclusion and Exclusion Criteria

In order to ensure that the study truly reflected the lived experiences of people working with and experiencing substance misuse issues, a number of criteria was applied.

#### **Inclusion criteria for Group A was as follows**

18 years and over

Working with substance misusers in the NEIC area

Or

Having responsibility for policy regarding substance misuse in the NEIC area

#### **Inclusion criteria for Group B was as follows**

18 years and older

Normally resident in the NEIC area

Experiencing or having experienced a substance misuse issue

Or

Having a family member either experiencing or having experienced a substance misuse issue

In receipt of substance misuse services

Or

Not in receipt of substance misuse services but experiencing a substance use issue

Having the capacity to give informed consent.

### **Exclusion criteria – Groups A and B:**

Under 18 years

Not resident or working in the NEIC area

Considered incapable of giving informed consent.

### **3.8 Challenges with the Study**

A decision was taken early in the research design process to avoid including the voice of service users in established statutory services. This was due to a number of reasons, including the fact that the HSE had commissioned its own quantitative survey on the experience of service users and that another qualitative report was due for publication on the experiences of people in receipt of long term Methadone Maintenance Treatment (MMT) in the South County Dublin area.

Of particular importance was the decision to include the voice of substance users who were not formally engaged in services in the NEIC. This involved allowing a considerable amount of time for the service providers to contact those particularly hard-to-reach substance users, who were often in very chaotic substance use, and for decisions to be made as to their capacity to give informed consent.

While fourteen of these substance users had arranged to meet the researcher, in many instances, appointments were missed, with no-shows and a number of re-schedulings involved. In addition, in order to avoid over recruitment of this group, Gatekeepers were approached sequentially, and it was only when it became clear that participants were not available that another Gatekeeper was approached. In instances where Gatekeepers attempted to recruit men and women, men did not attend for interview, reflecting a general unwillingness by males to engage in health research (Markanday, Brennan, Gould and Pasco 2013). As a result, more female service users (n=6) than male service users (n=4) took part. Although appointments were set up with substance users in homeless accommodation, they were not available at time of interview and could not subsequently be contacted.

Another issue that arose was that of the unwillingness of some participants to attend focus group interviews, or in some cases even a one-to-one interview in a specific location for fear of reprisal around drug related intimidation issues and feuding. As a result, many of the interviews in Group B took place in the individual's home or at a place (restaurant/coffee shop) of their choosing.

Also, while there is a considerable representation of service providers in the NEIC area, this is by no means exhaustive.

The criteria applied to this study meant that it represents the views of only native Irish people and there is no migrant voice.

## 4.0 PARTICIPANT PROFILE

### 4.1 Senior Stakeholders

The senior stakeholder focus group comprised 8 participants who were engaged either directly or indirectly (at policy level) in service provision and support in the NEIC area. Of the participants, six were male and two were female. Four of the participants were from Statutory bodies, two were from Community/Voluntary Agencies and two from Cross-Section agencies with a remit at both a Statutory and Voluntary/Community level.

### 4.2 Service Providers

Service Provider participants numbered eighteen. Of these, five were interviewed on a one-to-one basis, two in a focus group of two people. All seven of these participants were directly involved in service provision for individuals and/or their families in the NEIC area. Four of these participants were from the Voluntary/Community sector, two from a Statutory body and one from a NGP (Non-Governmental Organisation). Two were male and five were female.

The remaining 11 participants were representatives of a Working Sub-Group on Addiction, Health and Mental Health and were either directly or indirectly involved in service provision for substance users in the NEIC. Of that eleven, four were from NGOs, three were from the Voluntary/Community sector, three were from Statutory bodies and one participant was from a Cross-Section agency. Six of these participants were female and five were male.

### 4.3 Community Representatives

Eight community representatives were interviewed for this study in a focus group. All eight were from the Community/Voluntary sector engaged in development, project or support work in the NEIC area. Many were also resident in the area or had lived in the NEIC in the past. Of these, seven were female and one was male.

### 4.4 Family Members

#### 4.4a Gender, Age, Martial Status and Children

In total, nine family members were interviewed. One of these interviews was omitted as the participant was not living in the NEIC area and so did not fulfil the study criteria. The remaining eight were all female. Their age range was from 30 to 69 years with an average age of 44.5 years. Six family members were single (never married or married now separated) and had between one and three children. A further two were married, one with children and one without.

#### 4.4b Education and Employment

Seven of the eight participants had left school before Junior Certificate, with only one continuing in education to Leaving Certificate Level. Three participants had returned to education as adults. Regarding employment, five of the participants were employed, two were on a CE scheme and one was unemployed.

#### 4.4c Housing

Three participants were in stable housing. Two of the participants had experienced homelessness at some stage in their lives and three had experienced housing instability as a result of being in private rented accommodation.

#### 4.4d Bereavement

While these participants were not asked if they had experienced the death of a family member through substance use, four volunteered that they had experienced bereavement and a further two stated that they had family members who were in the Criminal Justice System at the time of interview.

#### 4.5 Service and non-Service Users

##### 4.5a Gender, Age, Martial Status and Children

In total, eleven service and non-service users were interviewed. One of these interviews was omitted from analysis as the participant was not living in the NEIC area and so did not meet the study criteria. Of the remaining ten, four were male and 6 were female. They ranged in age from 23 years to 54 years with an average age of 32 years. All of the six women were single parents with between one and four children each. Of these, three had their children living with them. One Mother had two of her children taken into care and was due to have them returned to her, while one was still in her care. Another Mother had children who had been raised by their grandparents close to where the mother lived (with regular contact) and a further three Mothers also had family support for their children when in chaotic substance use or during periods of residential detoxification. All of the men were single and had no children.

##### 4.5b Education and Employment

Six of the ten participants were early school leavers. Of those, three had not moved beyond primary education - one had left on completion of primary school (female) while a further two had been excluded at ages 10 and 12 (male). Three had left prior to Junior Certificate and three had completed Leaving Certificate. Three of the participants (all female) had returned to education as adults. Two of the males in the study were working full time – one as a sessional labourer and one as a semi-skilled labourer. Three of the women were employed as part of a CE scheme. The remaining participants (n=5) were unemployed at the time of the study.

##### 4.5c Housing

While six of the female participants (who all had children) were in stable housing, they had experienced bouts of homelessness and housing instability throughout their lives. Two of these had recently been housed. All of the males (n=4, average age = 25 years) were living in the family home.

##### 4.5d Substance Use History and Current Use

Eight of the ten participants described their initiation into substance misuse as beginning with one or two substances and escalating quickly into poly-substance use. Only two participants were single substance users (one had used heroin only and the other alcohol only).

Nine of the ten participants had started substance use in their early adolescent years. With the exception of one outlier (female aged 27 at time of initiation) the average age of first substance misuse was 12.6 years. Of the female participants, one participant had an alcohol misuse problem which started at age 12 (and was at the time of the study alcohol-free) while a further participant had started with heroin at age 14. The only participant who started their substance use as an adult was 27 at the time of initiation. Both of these participants were engaged with services and on MMT. One was taking street tablets in addition to dispensed methadone.



One of the female participants had started substance misuse at age 11 with marijuana and alcohol and had moved on to cocaine and heroin. A further two women had started substance misuse at the age of 12 – on starting with Valium and hash and moving on to heroin, crystal meth, cocaine, crack and alcohol while the other started with hash and alcohol, moving on to heroin at the age of 14 and then over-the-counter (OTC) codeine-based medications. At the time of the study, these three participants were substance free.

Two of the males were not engaged in services directly but were part of a service provider's outreach programme. One had started on ecstasy and alcohol at 13 years and was at the time of the study using street tablets, crack cocaine, heroin and alcohol. The other male had started cannabis at age 12 and was at the time of the study using cocaine, Valium, weed, alcohol and heroin. Although not asked, these two males volunteered that they had spent a considerable part of their lives in and out of the Criminal Justice System.

A further male had started at age 15 with marijuana and moved on to cocaine, MDMA (methylenedioxy-methamphetamine), and alcohol. At the time of the study, this participant was using marijuana and alcohol and occasionally cocaine (weekend use). The other male had started using cocaine at the age of 13 and had moved on to Ecstasy/MDMA, Ketamine, weed and alcohol. At the time of the study, this participant was substance free for a number of weeks. While not formally in a treatment programme, these two males were linked in to services accessed via a youth service they had been involved with during their childhood.

## 5.0 FINDINGS

The following chapter contains the findings from the interviews conducted for the study. The findings are presented by group – senior stakeholders, community representatives, service providers, families and service/non-service users.

Analysis of the data collected saw the emergence of a number of themes broadly evident in all of the groups from both A and B (See Section 3.3). These themes focussed on three main issues around substance misuse in the NEIC. The first of these was that of system failures around service provision and engagement. Systems in this instance refer to existing service provision, policy around such provision as well as the mechanisms for cohesive working between various groups tasked with service provision and implementation.

The second theme was that of social issues around substance misuse and includes findings on housing and homelessness, drug related intimidation as well as children and young people.

The third and final theme centered on what the participants felt was needed to move forward on these issues, and includes findings on the meaning of recovery, education and prevention as well as, in some instances, proposed strategies for moving forward.

### 5.1 Senior Stakeholder Findings

The following section outlines the findings from the eight senior stakeholders interviewed for this study. This focus group of eight people represented a number of Statutory, Community/Voluntary and Cross Section Agencies. They are tasked with overseeing policy and implementing change on substance use issues in the NEIC.

#### 5.1a Systemic Barriers to Treatment Provision and Engagement

##### 5.1a (i) Drug Use Trends and Service Provision

Senior Stakeholders acknowledged that poly-substance use is a very real issue in the NEIC area and more prevalent than in other areas in Ireland.

*‘What’s striking about this particular area is the poly-substance abuse seems to be a broader problem than it would be in other areas and that’s tablet abuse seems to be very problematic ... the ease of access to tablets (not just opioid tablets) ... sleeping tablets, benzodiazepines ... and some of the what’s going on around the place isn’t necessarily related to heroin – it isn’t heroin related it’s tablet related.’* (Joseph, Statutory Agency).

*‘The tablet use is very different, and we don’t always have medical responses easy to hand for when the primary issue has become tablets and very often (these) people ... don’t see themselves as having an addiction issue so they don’t really present.’* (Tom, Community Voluntary Agency).

*‘The tablet use is constantly changing and the resources – for example if somebody is (on five trays of tablets there’s no resources) where do we refer them to? There is no treatment or rehabilitation centres that will take them on to detox off, so your hands are tied as a worker – how do you refer these people on to crack cocaine and cocaine itself (and cocaine/crack cocaine) is socially accepted as well, people don’t see it as a problem.’* (Emer, Statutory Agency).

This constant need to be able to respond to changing drug trends limits the amount of time that can be spent on monitoring and evaluation of service provision.

*'Often because the challenge is so big and people are working so hard ... there isn't enough time for looking back on what's working and what isn't working and the whole notion of reflection and evaluation of the stuff ... there isn't enough of that and that you're responding to whatever the current thing is.'* (Patrick, Cross Section Agency).

Participants described the difficulty in overcoming perceptions of treatment projects and the lack of services designed for men.

*'A lot of the services are holding these older drug users that (had) massive issues years ago and we can't just let them go ... we have a duty of care to them and I think that where there's a gap in Dublin particularly ... I don't see it as extreme when I go to any of the Regional Task Forces. We were set up to respond to opiates and we still have that label. Younger users ... women who are just tablets only or just alcohol or even from different communities ... I think those gaps are there and in this area – we have no CE or day programme – whether its CE or not – for men. We're lucky to have one for women but we don't' actually have an easy access programme that you could send men to.'* (Tom, Community/Voluntary Agency).

#### *5.1a (ii) Drugs and Alcohol*

The absence of alcohol interventions was also discussed.

*'We don't even get near ... alcohol – there's a huge alcohol problem as well in behind that. There are treatments but ... they're quite limited and there needs to be a lot more work done at a community level. There is stuff that can be done in conjunction with Primary Care Physicians if the PCP was on board and working with the Drugs Project the answer isn't always getting someone into a bed for detox – its supporting someone through a programme in the community. Someone with an alcohol problem (is not) going to be entirely comfortable walking in the doors of City Clinic if everybody else is getting methadone.'* (Kevin, Cross Section Agency).

*'That's a big, big thing. We do have a significant problem with young people and alcohol – the parents have a really important role to play in being role models in the first instance but then starting the conversation and engaging the young person in a recognition of the harms.'* (Joseph, Statutory Agency).

#### *5.1a(iii) Care Planning*

The lack of care planning was of concern to half (n=4) of the participants.

*'Treatment seems to be a little bit isolated and not as engaged and so ... we're looking at this particular area (to introduce a) case management approach whereby all of the agencies would be using a similar type of assessment, have the ability to share information about drug use to improve their situation and ultimately improve the situation of the community at large.'* (Joseph, Statutory Agency).

*'I think the HSE ... do have to be cognisant of the broader situation linking people in with progression routes – linking people in with the services that are out there and talking to the services and that's maybe been a problem – treatment seems to be a little bit isolated and not as engaged.'* (Joseph, Statutory Agency).

#### 5.1a (iv) Mental Health

The link between mental health issues and substance misuse was of concern to over a third (n=3) of the participants.

*'There are other strands then – there is a big issue to do with the whole issue of mental health and addiction that's something that is very relevant here.'* (Frank, Statutory Agency).

*'Mental illness and substance use - we see so many (substance users) that come in that have schizophrenia, or bi-polar, personality disorder all these mental disorders that they are actually diagnosed with and we wouldn't be equipped with the skills we would try to refer them on but there is no one to refer them on to ... having ... dual diagnosis to help people understand mental health and substance use.'* (Emer, Statutory Agency).

*'Mental health area seems to be an area where there are massive problems because it comes across in schools, in people looking for just assessment never mind anything else. Where you have kids who are in a really bad way — it's really an ostrich in the sand approach ... about it. (We are) very anxious that mental health and the addiction issues be linked.'* (Patrick, Cross Section Agency).

#### 5.1a (v) Interagency Co-operation

The majority (n=7) of the participants felt that there were considerable problems with Inter-Agency co-operation, both between State, NGO and Voluntary/Community groups as well as a disconnect between medical and non-medical professionals.

*'We have a contractive model of the state especially in these areas of difficult social services which I think can be problematic – and that's where we get these multiplicities of organisations, multiplicity of funding streams – but its planned – because no one else is taking responsibility for it.'* (Frank, Statutory Agency).

*'On treatment we need a continuum of care type of approach, we need care planning and again that needs to be linked across the board and ... often there isn't a coordination between that, the housing, the DCC (Dublin City Council) so that whole issue of linked up approach there's a whole multitude of agencies services both in the NGO and community sector and in the statutory area dealing with this but there isn't enough integration between them.'* (Patrick, Cross Section Agency).

*'It's a challenge absolutely and one of the challenges is ... (that) sometimes medical professionals are a bit reluctant to share certain information with non-medical professions – so I think there's a bit of work to be done in that regard.'* (Joseph, Statutory Agency).

*'But ... if we do work together in an honest way then we can certainly improve some of the difficulties ... but it has to be honest. There is a real opportunity to do something significant despite it being a huge challenge'* (Patrick, Cross Section Agency).. *'Because it isn't just about North Inner City – there's other people throughout the country. It's about how we address these tricky problems that are full of challenges in the best possible way.'* (Frank, Statutory Agency).

#### 5.1a (vi) Buildings and Facilities

Part of the problems facing service providers in the area is the condition and age of the buildings in which they operate.

*'Facilities, I think are a huge issue for many of the established projects and even for some of the statutory services as well in terms of ... the actual buildings people are in and how unaccommodating they are. Very few of the projects that are funded through the task force are really fit for purpose'*

*and even inaccessible to people who might have mobility issues, a disability from that point of view and it is an ageing population with increasing mobility issues.'* (Tom, Community/Voluntary Agency).

*'Facilities is huge just around people that would have disabilities as well that would just try and access as well – all the buildings are old and there's no lift.'* (Emer, Community/Voluntary Agency).

## 5.1b Social Issues around Service Provision and Engagement

### 5.1b (i) Housing and Homelessness

Housing supports are seen to be essential to those engaging in services and lack of co-ordinated Government policy is seen as an issue in this regard.

*'If you're looking to move from harm and to support (substance users) in recovery homelessness is huge ... the issue of the inter-connectedness of the drugs issue specifically with the homelessness issue (we need to) get that linked up between addiction and housing and homelessness policy and where is initiatives over homelessness and addiction how we can bring those together in this specific locality.'*

*'The way the state has dealt with a lot of these issues. Homelessness is a good example - basically hands it over to the voluntary sector and maybe the same has happened to some extent on the drugs issue so difficult topics to say right – here we're giving you resources go and deal with this. I mean I don't think other societies would the same – would just kind of stand back and ok – we're giving you as much resources as you want, just go and do it – the state should be more directly involved in managing and addressing these issues.'* (Frank, Statutory Agency).

### 5.1b (ii) New Communities

In recent years there has been an upsurge in the amount of new communities coming into the area from other countries, which has placed additional pressures on housing and three of the participants had concerns about the lack of forward planning on integration and other social issues, including future entry into substance use supports.

*'Migration is going to be a massive issue. New communities is a whole new area that maybe is not urgent yet but it's important because it could quite easily become very important and the absolute need for us to do it right across the board from school children - one primary school has nearly 50 or 60 per cent of pupils (who) are international right through to the secondary schools. How do we link and how do we prevent and how do we treat people who are from new communities and don't have the same obvious inbuilt connections to drug services?'* (Patrick, Cross Section Agency).

*'There is massive social change going on. You have (named street) – where we're bringing people in and in all honestly there's people in the locality effectively – you deal with one problem and now suddenly you've another problem – we'll have another one.'* (Frank, Statutory Agency).

### 5.1b (III) Drug Related Intimidation and Policing

Half of the respondents (n=4) discussed the issue of drug related intimidation, the constant level of threat felt by residents and the lack of safety.

*'The biggest (issue) raised by local residents who are part of the community would be the issue of intimidation, anti-social behaviour, criminality.'* (Patrick, Cross Section Agency).

*'The amount of violence that would happen after hours and throughout the morning is ongoing 24 hours, 7 days a week all throughout the year -(you're) ... putting yourself in danger as well but you're thinking 'that's an individual's life that somebody's head is actually getting stood on' ... that's how descriptive you have to be to understand what's happening on the streets after hours.'*

*'There is no safety for people to come forward with drug intimidation. We were working with a lot of people that when you were trying to get them to safety or you were trying to report it you were moved from pillar to post to Garda station to Dublin City Council – there's no one designated person to go to that (has) all the links so that you feel safe.'*

*'There is police visibility ... but it's just that containment issue. They'll be in one area for a while and they'll remove them from that area - it's just moving around but the violence ... even the shootings that's been around the area ... there was somebody just driving around shooting out of a car – you don't even know sitting in your own home and you've got nothing to do with anything but it's a violence that's in the area - so nobody is feeling safe at the moment.'* (Emer, Community/Voluntary).

#### *5.1b (iv) Children and Young People*

More than half (n=5) participants discussed problems with children and young people acknowledging that substance misuse affects every aspect of life in the NEIC, from childcare provision, to school and beyond and well as having intergenerational implications.

*'When you talk to some of the afterschool ... a lot of their parents have been affected by that and that has affected the lives of their children and the lives of the children in school so I think it has tentacles into every facet of life of the people in the place.'* (David, Cross Section Agency).

*'The integrational piece ... you'd have a lot of families where you've got grandparents, parents and children all in the cycle as well.'* (Eva, Statutory Agency).

*'And ... child care provision is hard anyway in the area but child care provision to work with families who have addiction issues and have an understanding of addiction is just absent. And that's needed because the intergenerational piece. Part of that work of just responding to the early childhood needs ... (to ensure) all these kind of basic responses are dealt with and people who are in early stages of recovery don't always follow up or ... don't know how to and they need a child care service that can support them and can work with them in that way. And we don't have those spaces in the area ... but it needs to be addiction aware rather than just a child care service.'* (Tom, Community/Voluntary Agency).

Young people in the area get involved in drug markets at a young age, both as substance users and as part of the larger drug gangs.

*'Youth use of weed ... is adding to the social problems, adding to the levels of aggression and to the mental health difficulties and ... whether they would ever present at a service would be questionable, but they are certainly adding to the complications in households.'* (Tom, Community/Voluntary Agency).

*'For the youth that's out there they're seeing how glamorous it is that these lads are left on the corner selling drugs and I know the police are doing well and they're picking them up but they are also seeing them in new cars, new shoes they're seeing them going on holidays – they're seeing them going out so there's something glamorous even though we know it's not glamorous. It's in every corner, it's in every piece of this community and you can see it ... seeing 12 year olds (are now) the dealers – nearly kind of groomed into this position. And the level of violence is kind of shocking you know. And It's going on from a young age and right up and it's ongoing.'* (Emer, Community/Voluntary).

## 5.1c Moving Forward and Recovery

### 5.1c (i) Education and Prevention

The participants discussed the need for wide-ranging education and intervention that is consistent and co-ordinated.

*'There is a need for a more integrated co-ordination to prevention and education...there are some useful programmes ... but there has been no consistency over the years, there hasn't been any approach that all primary schools, all secondary and all third level institutions in the area are providing ... (that is) evidence (based).'* (Patrick, Cross Section Agency).

*'There needs to be more prevention and education into young kids ... with Tusla and the ETB (Education Training Board) and what can be done and put in place.'* (Emer, Community/Voluntary).

*'This is a very contested area in schools, it's not straightforward.'* (Frank, Statutory Agency).

*'And in connection with youth services as well in the area and just reinforcing that level of integration.'* (Kevin, Cross Section Agency).

### 5.1c (ii) Recovery

The concept of recovery was understood by the participants that discussed it (n=4) as to mean a range of engagement with services and spanned from abstinence models to harm reduction, with everything in between. However, moving forward posed problems in terms of housing and potential employment.

*'For some people long term methadone is the answer and for others abstinence – but one side can't say your way is right or my way is wrong – you've got to realise it's a continuum.'* (Joseph, Statutory Agency).

*'The other whole area of spent convictions that's not being looked at ... but there's lots of barriers for people when they're moving on in recovery and usually their record or their criminal record of their past can hinder or stop them and if you're trying to sell the idea of recovery you know and you're saying oh you'll be homelessness and you'll never get a job – you're not really selling the idea.'* (Frank, Statutory Agency).

## *Summary of Senior Stakeholder Findings*

### **Systemic Barriers to Treatment Provision and Engagement**

*Poly-substance misuse and inapt treatment criteria*

*Absence of alcohol treatment programmes*

*Care planning not embedded*

*Deficiencies in services for men*

*Inadequate mental health and substance misuse links*

*Inconsistent Inter-Agency co-operation*

*Unsuitable facilities/buildings*

### **Social Issues around Treatment Provision and Engagement**

*Housing and homelessness*

*New community integration*

*Drug related intimidation and policing*

*Children and Young People*

### **Moving Forward**

*Education and Prevention*

*Recovery and Recovery Capital*



## 5.2 Service Provider Findings

The following section outlines the findings from the eighteen service providers interviewed for this study. Seven of these interviews were carried out with service providers directly tasked with substance use service provision and operated in situ in the area. A further eleven people, part of a working group, comprised participants both directly and indirectly involved in service provision in the NEIC, but not necessarily situated in the area.

### 5.2a Systemic Barriers to Service Provision

#### 5.2a (i) Drug Use Trends and Service Provision Criteria

Almost two thirds (n=11) of service providers were concerned about the increase in poly-substance use in the NEIC and the effects that this had on service provision.

*'Yeah we have this fancy term for it (poly-substance use) but if you're an addict you're going to take whatever gets you through the day.'* (Deirdre, Community/Voluntary Agency)

Ellen, who works with young people noted that poly drug use is 'high up there' amongst young people: *'so you've got your cannabis only guys then you've got cannabis and cocaine, cannabis and benzos, cannabis and tablets, cannabis tablets and benzos ... cocaine and gambling...alcohol...crack'.*

*'Teenagers ... do their own thing – so cocaine and cannabis is the main thing ... drug deaths are going way up because of the amount of cocaine involved. One young person dies a month so it's been a major issue there.'* (Aaron, Statutory Agency).

These changing patterns can be mapped over the past 25 years, from predominantly heroin use over 20 years ago to the 'cocaine epidemic' ten years ago, followed by synthetic drugs from the Headshops in 2010 until their closure in 2011. Since their closure, drug trends have changed again.

*'Then when the shops shut then benzos made a big comeback and the young people were more involved in benzos then and cannabis so we just had to stretch it out to like a poly drug use service ...'* (Ellen, Community/Voluntary Agency).

*'What we would have been dealing with 25 years ago would have around heroin use ...and all the services I suppose were geared towards that ...but now it's more weed, its more tablets, its more poly drug use.'* (Julia, NGO).

This change in pattern of poly-substance use brings problems with service provision in that most of the services have specific treatment criteria which excludes people with poly-substance misuse.

*'The main pattern of drug use now and for the last couple of years is tablet abuse ... so in order to get into most of the detox beds in the country you need to not have any benzos or tablets in your system...so there's cocaine rehabilitation beds but because it's not physically addictive there aren't detox beds ...'* (Dara, NGO).

*'We do need to look at what people are doing and how that responds to the needs of the people as the needs change. Everyone talks about heroin all the time - but it's not an opiate problem alone any more so we need to be open to that.'* (Ian, NGO).

### 5.2a (ii) Drugs and Alcohol

More than half (n=10) of the service provider respondents talked of the lack of services for alcohol misuse, an issue common to all age groups and substance use clients.

*'Alcohol has always played a really major part in the addictions of the North Inner City – well of the country really but particularly in our area so often people will start with alcohol move into opioids and then reverse back into alcohol again so that movement from one addiction to the other it's very – common in our patient group.'* (Aidan, Statutory Agency).

### 5.2a (iii) Detoxification/Stabilisation Facilities

The lack of detoxification and or stabilisation beds was an issue for over a third (n=8) of the service providers and there was considerable discussion about the need, particularly in relation to poly-substance misuse, to take even one substance out of the picture.

*'We have nowhere to put somebody who is very, very chaotic on poly-substance misuse ... if we had that facility where somebody could stabilise and even take out one drug out of the scenario – so they were abusing large amounts of tablets that we could stabilise the tablet misuse and stop them misusing heroin then they come back out and they can kind of progress.'* (Aidan, Statutory Agency).

*'For someone to self-detox or to detox out in the community is extremely high risk there needs to be a level of medical supervision – it's just not realistic for the chaotic profile of many (people)'* (Frances, Statutory Agency).

*'Basically (somewhere where) people can turn up, get assessed and if there's a bed they can go in...if there's not a bed they come back and have a harm reduction intervention each day until there is a bed and the person most in need gets prioritised ... they come in and they are stabilised and then they look at whether someone can detox or...leave stable. Knowing the area and knowing the issues ... this would have a huge positive effect on the issue here.'* (Ian, NGO).

*'It's important to have local accessible stabilisation and detox in the area and not to be sending people down (the country) but also ...we need to be able to send people down to (the country) when they want to because some of the feedback is "I can't go to treatment in my own local area" (for a variety of reasons) then sometimes people just want to get out of the city it's a psychological thing like ... so its kind a of a blended approach that is needed.'* (Dara, NGO).

### 5.2a (iv) Care Planning and Case Management

More than half (n=10) of the respondents were concerned about the lack of care planning or case management for substance users seeking treatment, noting that it is not an embedded concept.

*'I think one of the things we are quite deficient on is care planning...a structured care plan that actually takes out some of the chaos, because often we are ... responding to crises. Care planning (is) not something that was ever built into the system so we've never had key workers or case managers...some of the outside agencies but... I don't think it's embedded hugely in the Irish drug treatment culture.'* (Aidan, Statutory Agency).

Care planning can often be ad-hoc, developed by the service providers themselves and not formally funded and as such can have a limited reach.

*'So what we do here with the very limited resources we have is we build relationships with them...we put a care plan around them ... contact their doctor...get their family involved if we can.'* (Deirdre, Community/Voluntary Agency).

*'In many ways our staff are doing case management, which is the big push from the HSE and we are there pushing it as well but we don't always have the authority to do it so I can't as a case manager, ring up a doctor and say "you must do this" or "you agreed to do this why aren't you following up on it?". I can't do that with other agencies.'* (Peter, Community/Voluntary Agency).

Service providers also saw a very clear need to provide outreach and in-reach services as an extension of case management, which again is funded for some service providers but not for others and that this could be beneficial in identifying what additional supports a person or family may need.

*'It's case management of that person for a short period of time and specifically in the NEIC so our case management team work with people who use drugs and – sell drugs, going into people's homes is what is effective for them in terms of their confidentiality and their comfort to speak to us so we definitely meet them outside and in cafes and in (the service) building but we meet the families and we meet the parents and we end up picking up different pieces as well.'* (Dara, NGO).

*'It's...really beneficial in terms of monitoring the situation – people will often tell you stuff or not tell you stuff and when you go into their...I wouldn't call it home...but that's where they are living – you can really observe things so from not just an intervention perspective but in terms of knowing what the needs are like in terms of hidden harm for children in terms of whether people can cook for themselves – all these kind of things can be really assessed.'* (Ian, NGO).

#### *5.2a (v) Mental Health*

The majority (n=14) of the service providers interviewed for this study raised the issue of the need for greater collaboration of mental health and addiction services. In most instances, service provision in mental health services operates criteria that excludes people with substance use issues.

*'Mental Health services are separate to the addiction services – they're independent republics...but you can't do one without the other. Like a lot of our clients would be presenting mental health needs, that they have masked with addiction – it's like which comes first – chicken and egg?'* (Elizabeth, Statutory Agency).

*'A lot of our service users have very, very problematic psycho-social issues (and) while we can provide (treatment)... without too much difficulty it's often the more complex co-morbidities from the point of view of physical and mental health but also that psycho-social element...'* (Aidan, Statutory Agency).

This is particularly crucial for young people as the service providers working directly in youth services pointed out.

*'Young people today for lots of different reasons are arriving with lots of other complex issues which possibly in the past were masked by opiate use... or we have names for them now and we have boxes to put people in...but now there would be more issues like Autism, Asperger's, ADD, ADHD – there's names for lots of behaviours – there's lot more dual diagnosis. Mental health... personality disorders.'* (Ellen, Community/Voluntary).

*'What we're experiencing a lot in (service for young people) is the reluctance or in some cases outright refusal of the main mental health services to work with young people who are... using any kind of drugs or alcohol...*

[They just won't?]

*...they refer them on to us but we're not a mental health (service) .... so that management of acute mental health problems ... will require years of treatment and possibly in some cases it may look like a lifetime of treatment so it's a really crucial time for services like CAMHS (Child and Adolescent Mental Health Services) to get involved...early intervention before the mental illness really starts.'* (Aaron, Statutory Agency).

Progress had been made for a while, but then faded away: *'They (mental health services) sort of disengage because they said there isn't the focus on mental health even though we've agreed from day one addiction, mental health and health – they're all three that are connected – you can't separate them.'* (Elizabeth, Statutory Agency).

#### *5.2a (vi) Inter-Agency Co-operation*

This lack of integration of services is just one aspect of problems with Inter-Agency co-operation and collaborative working in the NEIC area between Community/Voluntary, NGO and Statutory agencies. Most of the service providers interviewed have been working in the NEIC area since the 1990's and have good working relationships with other Community/Voluntary or NGO service providers and will refer clients on where they feel it is in the best interests of the service user.

Problems arise, however, where there is a conflict of what those interests are seen to be alongside a perception of what a service provides.

*'Well we've lots of links with community voluntary agencies ... so we're all working with the same people but again the difficulty is many of the services have an idea of what we do but don't necessarily support it.'* (Elizabeth, Statutory Agency).

*'A lot of people are doing good work – but it's not a co-ordinated response – people are going in you're doing some pieces and nobody else knows what anybody else is doing ... that piece for the NEIC for somebody to have a co-ordinated response. Different services and the HSE can sometimes be doing one thing and there's not a joined-up approach.'* (John, Statutory Agency).

There is also evidence of lack of liaison between, for example, the prison service or the hospitals when discharging substance users: *'I think it's the onus is on everybody that works with the clients – I suppose any kind of person in management strategy level need to look at inter-agency working.'* (Aidan, Statutory Agency).

In addition, there was a concern about the amount of time that it takes for issues – such as changing drug trends or social issues – to 'filter up' to policy level.

*'I think that when you look at the data quite often its two years old at least and what we need is to for people to listen to us. That's we need – we need policy makers to listen to service providers about what's going on right now and be able to respond to the massive shifts. But if for example methamphetamine became a massive issue in the NEIC tomorrow we need to respond to that. (But) what you end up is months and months and years later you end up with a discussion about what's going on which was going on two years ago.'* (Ian, NGO).

The NEIC Programme Implementation Board came in for praise for initiating a very real knowledge and information sharing between all agencies involved in the area – including the HSE and the Criminal Justice System. However, there was concern about the lack of permanency of this structure.

*'It's very fragile in terms of leadership.'* (Dara, NGO).

*'The existing structure (PIB, Sub-Groups, Voluntary Organisations) that are representative is the only sort of structure at the moment and ... there is a lot of work that is happening on that basis – but is it sustainable? It'd be great to think that it could be but there might have to be a mandate there for this type of work to continue in this way in this area – a policy mandate.'* (Frances, Statutory Agency).

#### *5.2a (vii) Policy and Funding*

All of the service providers in one-to-one interviews (n=7) talked of issues around Government policy and funding of drug and alcohol services. In many sectors, especially the Community/Voluntary and NGO sector, there was considerable discussion about reduced funding, insecurity of funding streams and the time and effort that is taken up trying to secure additional funding.

*'There is a strong temptation to root the story of investigating service provision need in the present tense and ask "how do we move forward?" However, we got to where we are at through the decision to impose 25% plus cuts on all our projects and not witness the same pay/project and material restoration costs that many other sectors experienced. All of the drug projects were originally funded on a project model ...austerity did not cut back the scale of these projects at the same level, rather it demanded that the projects draw from additional funders to make a similar level of work happen (other grants, donations from churches, corporates, individuals, collections at supermarkets).'*

*'But this narrative is not recognised nor that the administrative burden had to be carried by the projects, itself further exacerbated by increased demands for compliance and accountability, all driven by an ideological framework in which named values such as care, compassion and trust (e.g. of the HSE) must be subject to market efficiency rather than the other way around.'* (Mark, NGO).

Many of the service providers talked about this administrative burden and the fact that it detracted from the day-to-day work of services and in many cases was so specialised that expertise had to be bought in and paid for.

*'There is never enough funding and the reason for that is the Government insists on adding new legislation and new expectations and ... signing up to governance codes and that all is administrative work and it all costs money and it all needs getting paid professional fees to get people to come in because the Government is requiring all these extra compliance things which can't be just done - experts have to be brought in or something has to be developed and it all costs money.'* (Ellen, Community/Voluntary).

A number of the service providers were also concerned about pressures on staff, and staff burnout.

*'It's gotten to the point now where I personally am quite burned out ... I had hoped ... we would get a bit more funding. Last year through (a) discretionary fund we hired someone for one year and I hoped that we could parlay that into getting someone permanent but ...(that) discretionary fund was only for one year.'* (Deirdre, Community/Voluntary).

*'I could do with at least another two project workers/case managers. Just for the numbers that we have. Because of the intensity of the work ... there is a lot of emotional stuff in the work ... so that staff are being impacted (with the life histories of clients and) the violence and assaults and even managing the mental health breakdowns ... and the poverty. (Service users) come here and they are hungry. And that is just wrong – in this day and age it's wrong.'* (Peter, Community/Voluntary).

#### *5.2a (vii) Buildings and Facilities*

Seven of the eight service providers who were interviewed on site stated that the building in which their services were located were unsuitable and inadequate. These buildings are generally older Georgian houses.

*'This ... building is still associated with heroin use...so I think sometimes kids didn't like to come if their uncle was here or their mam or if they've got issues with that – 'Oh are you going in there for the junkies?'* (Ellen, Community/Voluntary).

*'This building is not fit for purpose ... any (service user) with a disability can't come in here.'* (Peter, Community/Voluntary).

*'The building is totally inadequate to provide modern twenty-first century medical care.'* (Aidan, Statutory Agency).

#### *5.2b Social Issues around Service Provision and Engagement*

##### *5.2b (i) Housing and Homelessness*

It was the opinion of the majority (n=17) of the respondents that high levels of transient housing in the NEIC area creates problems for service provision across the board and both exacerbates the issue of substance use as well as making it difficult for service providers to manage.

*'So if I had to say the single most negative aspect of providing care has been homelessness. And it's devastating, and it erodes an awful lot of what you can do with other treatments.'* (Aidan, Statutory Agency).

*'(Homelessness) creates such an issue on so many different levels – first of all, it's bringing more people with very acute problems in as well as preventing anything being done with people so there's so much work going in but progress is not really getting to happen because people – are just back into the same situation again once they leave wherever they have got the help.'* (Claire, Cross Section Agency).

And while acknowledging that some progress in being made in terms of supported hostels which have primary care services and some substance management care, this is far from the case in all instances of temporary housing for homeless substance users, as other service providers pointed out.

*'It is good to hear that there is separate link workers going into the homeless accommodation but we're finding that the private ones ... are quite difficult to work with – because maybe they have been transferred from initially a Band B and the staff never ... they don't have a social care background maybe lack a bit of understanding with regards to issues that people are presenting with.'* (Barbara, NGO).

*'They're not social workers in any way shape or form they're security guards...so I think you rely on the will of the person who is running it which is not appropriate...you're dealing with a private company who are making a lot of money so the issue on that is there needs to be regulation.'* (John, Statutory Agency).



*'It's a key point to acknowledge that the issue of homelessness can also be a difficulty with living – a difficulty with somebody living independently being able to function independently...with the additional supports.'* (Frances, Statutory Agency).

#### *5.2b (ii) Drug Related Intimidation, Drug Debt and Bereavement*

Drug related intimidation and drug debt was an issue for over two-thirds of participants (n=12) in how they manage their day-to-day service provision. In some instances, individuals and families are unable to access supports for fear of being targeted for intimidation. This has created a greater need for outreach and in-reach supports. In other instances, times of service provision have had to change.

*'Intimidation...can be an issue for families or for people who use drugs to go to a certain area – everyone knows everybody and if you're seen walking into somewhere I know (counselling service) is amazing and they do brilliant work, but we have families who would be really averse to going there because of where it is.'* (Claire, Cross-Section Agency).

In some instances, drug related intimidation is subtle.

*'But you can't ring in to say there's just a person parking outside their house and it's so – they know what it means – the person who's doing it knows what it means – but stuff like that is very hard to capture ... you can't go to the guards and say someone's parking...'* (Barbara, NGO).

However, oftentimes it is not, as one service provider working with families pointed out.

*'Kids are getting knee capped every other day, kids are getting shot but nobody cares because they're not dead. You know it's horrific.'* (Julia, NGO).

This intimidation is widespread in the NEIC area, even for those not involved in drug markets.

*'There's also people out there that don't owe money for drugs that's being intimidated so would that come under this as well because there are people living in fear at the moment you know...the dealing that's going on.'* (Claire, Cross Section Agency).

Service provision for young people works best when the family are involved but issues around drug debt have created the need for an evening service: *'We will always let the families know that there is more chance of a successful outcome for the young person if the family are involved...but... an awful lot families are working to pay off drug debts so... we have that service where I work late two nights a week so we have a drop in available we have a family group ... so that families can easily access us.'* (Nuala, Community/Voluntary).

The issue of drug related intimidation and drug debt when families are faced with the bereavement of a member who has died as a result of substance use exacerbates their problems.

*'Bereavement ... nobody talks about it. Everybody talks about drug related intimidation because it's in your face whereas bereavement a lot of the families ... they haven't got the luxury of grieving...because of all the other issues that come with it that. Family members are so stressed after the death because of drug related intimidation, kinship care (having to care for parent-bereaved grandchildren) because of money owing to a funeral director.'* (Julia, NGO).

Family members are often forced into further debt having to approach money lenders for loans to cover funeral costs because they *'had to give two or three thousand euro (to the funeral director) before the body would be taken...so that's horrible.'* (Julia, NGO).

### 5.2b (iii) Children and Young People

The age of young people both using and dealing in drugs was a major concern for more than half (n=10) of the service providers.

*'If you're taking a drug history from one of our patients ... you will often find that they will have started dabbling in drugs when they are 8 or 9 years of age and – now often sometimes within a family scenario – maybe they're stealing the mother's tablets or the granny's tablets or taking a bit of this that or the other – a bit of alcohol.'* (Aidan, Statutory Agency).

*'The age of the dealers in the younger are so young that they're not even engaging in education and they're 12, 13, 14 they're very, very, young ...and young people here would have a lot of drug debts...the young people that are intimidating are extremely young – you're talking about 15 and 16 year olds knocking on doors intimidating families so even the big drug dealers they have the little fish doing all of this work maybe to pay off a debt they have themselves – you get that money for us and we'll wipe out your debt.'* (Nuala, Community/Voluntary).

In many instances, drug use in young people brings with it a level of violence in the family home.

*'We're seeing a lot ... of child parent violence, so a lot of younger people are using drugs and there's a lot of violence because of weed...*

*'We would have heard before the services heard about it. I was talking to (Child Care Agency) last week... they're seeing it now ...but we got it from the families... the shame and embarrassment of that – the stigma of having somebody on drugs but then the shame and stigma attached to your child hitting you or your grandchild hitting you I mean it's horrendous.*

*'But I just believe that our children don't realise their worth, their value – they're not cherished the way kids are from other areas and I think we need to instil that in our kids. Our kids' role models are people who go around in big cars and ... I mean if you're someone who is living in an area and you know your Mum and Dad doesn't work or can't work or whatever or your Granny and Granda whoever is rearing you and you know you're looking at somebody and all you have to do is run with a box of drugs or a bag of drugs or hide them or whatever why would you not do that? You know?'* (Julia, NGO).

### 5.3c Moving Forward

#### 5.3c (i) Education and Prevention

Education and prevention strategies, according to the majority (n=12) of the service users need to start at a very young age and filter up through all age groups to include parents, schools and service providers to create an 'addiction aware' environment.

*'In terms of prevention strategies...it does seem kind of outrageous to – because you... almost need to be it putting into early national school – prevention strategies. They start drugs very, very, young and so often the preventative element often comes too late.'* (Aidan, Statutory Agency).

One service provider talked about the need for 'addiction aware' services for parents with very young children.

*'If women are involved in addiction or if they are in families where there is addiction – let's say they're not but the partner is – they are incredibly isolated for the first year of that child's life at the moment and that for me is a huge concern and I just feel that a regular creche is not going to be able to provide that.'* (Peter, Community/Voluntary Agency).



It was felt that there should be education *'across the services – the community services and ourselves around addiction and around the needs of the addiction in this community. I think there is a basic lack of knowledge that contributes to a lot of problems.'* (Elizabeth, Statutory Agency).

#### *5.3c (ii) Recovery and Recovery Capital*

The concept of what the term 'recovery' meant was generally agreed across all of the service providers who stated that 'recovery' started once a person sought help out of addiction and every step along their individual path.

*'Recovery... is really, really, important but I do think that it's part of a you know continuum if you like – stabilisation, recovery and it has to be set by the client in consultation... recovery is different for different people.'* (Ian, NGO).

*'Let's start with something that like – can we get your drinking under control or could we get your tablets under control or you know can we re-link with social services so that you can begin to re-establish contact with your family.'*

*'For me what recovery means is progressing out of drug use in a way that is dictated by the patient and it's a journey it's not a point ... most of the addictions are chronic relapsing addictions. There are clear damage to brain pathways that can often never be reversed. To me people who use two bags a heroin a week some of them still injecting – they're keeping their homes, they're keeping their families they work full time – that's recovery ...and often people don't see those people because ... they're marginalised ... stigmatised so they want to not be the ones who are agitating for 'recovery' – so these are people who do exceptionally well ... and to me they're as much in recovery as somebody who goes to AA every night and doesn't take a thing.'* (Aidan, Statutory Agency).

*'When you are working with somebody whose children are in care, they're avoiding prison they're being pushed into prostitution by a partner who is violent and they don't have enough money to feed themselves – they are in unsafe accommodation wherever they are and they have possibly been through domestic violence as a child anyway – drug free is not high on the agenda you know? So by the time you've got to stabilising an environment, helping her to manage the violence that she can't leave, drug use might then become a discussion.'* (Peter, Community/Voluntary).

*'Recovery work is not just a different model for supporting people ... it has a completely different rhythm and outlook upon all its activities that challenges our assumption about all elements of how we run projects including HR, funding, supervision and more.'* (Mark, NGO).

Service Providers also discussed the need to move away from substance misuse as a criminal issue and towards a health model of care.

*'Service delivery and service models can only do so much when the policies that are governing them are incorrect. Drug use is (seen as) a criminal behaviour...not health ... I just think we need to work on that. We have a microcosm in the NEIC of a lot of young people who are criminalised very early from (drug markets) ... (and when) they're ready for employment ... we can't get them employed because the amount of charges they have and the drug courts are not rectifying that for the people we work for. That's just not meeting their needs.'* (Dara, NGO).

Also discussed was the amount of time it takes to help someone progress on that recovery journey.

*'The current view is...we're being driven by the National Drugs Strategy one of those innocuous phrases of 'increased treatment episodes' – in reality means that treatment becomes shorter. Research...highlights that longer connection is much more beneficial.'* (Peter, Community/Voluntary Agency).

Discussing one service user who is currently in third level education following long-term intervention by services he explained that (shorter treatment episodes) *'would be inaccurately representing the work that we're doing because sometimes 7 years is a good investment. It's 7 years of intervention so it's no quick fix. So that idea of speedier episodes of treatment is problematic I think.'*

## *Summary of Service Provider Findings*

### **Systemic Barriers to Service Provision**

*Poly-substance misuse and inapt treatment criteria*

*Absence of alcohol treatment programmes*

*Lack of stabilisation and detoxification beds*

*Care planning/case management not embedded*

*Deficiencies in services for men*

*Inadequate addiction/mental health dual diagnosis approach*

*Inconsistent Inter-Agency co-operation*

*Funding cutbacks and bureaucratic burdens*

*Buildings and facilities*

### **Social Issues around Service Provision and Engagement**

*Housing and Homelessness*

*Drug related intimidation and drug debt*

*Children and Young People*

### **Moving Forward**

*Education and Prevention*

*Recovery and Recovery Capital*

### 5.3 Community Representative Findings

The following are the findings from the Community Representatives interviewed for this study. They comprised eight participants who represent the voice of the NEIC Community. All of the participants had some involvement in substance use projects or community organisations and in many, but not all instances, were also resident in the area.

#### 5.3a Systemic Barriers to Service Engagement

##### 5.3a (i) Drug Trends and Service Provision Criteria

The majority (n=7) of the Community Representatives discussed drug trends and the issue of treatment where there is poly-substance use. Many have lived and worked in the area since the 'heroin epidemic' in the 1990s and found that services have not moved with changing drug trends. They expressed a level of frustration that additional funding plans still centered on heroin and opioid dependence. The lack of treatment choice was also an issue for these participants.

*'Just around the trends ...it was heroin ... now it's not the primary drug – but it's still around the same as cocaine and crack cocaine is on the increase again (but) there's other things – the tablets. (We) really have to talk about tablets because the thing is nowhere (is there) anything about setting up resources for people that's on tablets – nowhere at all on it. There's no detox beds for anybody with tablet use – they're telling them to reduce themselves. The doctors are literally saying 'you're on five card – reduce yourself down to four and come to me'...sure if a person could do that they wouldn't need a doctor or treatment. There is no facilities – there's no resources. They want to address the issues that's the drug trends on the streets – they have to think about putting resources together for people that's on weed or people that's on tablets – they're the drug trends that's growing and growing so why are they ignoring them?'* (Karen, Community Representative).

*'It's not set up for tablets – no-one is set up either for to detox off tablets.'* (Josephine, Community Representative).

And equally, the fact that some protocols were developed but never implemented.

*'They invested money into the (Service Provider) who (developed) a brilliant benzo detox protocol and there was a whole system set up that you worked with the doctor you worked with the community service you worked – absolutely brilliant on paper but then – that's it – it was just left then. It was never implemented.'* (Karen, Community Representative).

The lack of recognition of poly-substance misuse and funding directed towards opioid dependent treatment can lead to people being refused treatment because their drug use does not meet treatment criteria.

*'(The HSE) is talking about putting it into the opiate treatment centres – back into the clinics – the clinics are not resourced to deal with the tablet use.'* (Karen, Community Representative).

*'I brought (a service user) a good few months ago (to service) and they would not take them because they were never on methadone.'* (Josephine, Community Representative).

And even if a substance user did present and was accepted for treatment, it was felt there was a considerable lack of choice around treatment.

*'There is no choice of treatment. There is no – an individual goes in first of all to a methadone clinic because the opiate treatment centres – that's what they give them - they offer them methadone.'* (Karen, Community Representative).

*'There's a lack of treatment choice...these people are being brought into these clinics and being left on this methadone...but what we are dealing with now is totally different. There's a lack of care planning overall – you go into these clinics – like you know they're treating them clinically... and methadone does not suit everybody. And there you have a whole generation of – the grandchildren as well on methadone too.'* (Josephine, Community Representative).

There is a sense that having no control or options over treatments is a disempowering experience for service users.

*'I think it's very disempowering to go to somewhere and be like – "this is what you're going to do. There you go see you later."* (Roisin, Development Worker).

*'And that's what is happening – that is what has been happening since 1995.'* (Karen, Community Representative).

*'Most of the service users don't get listened to – especially in the clinics – they do not get listened to.'* (Josephine, Community Representative).

#### *5.3a (ii) Care Planning*

There was considerable discussion about lack of care planning and the need for key-workers and a form of a 'wrap-around' for service users.

*'It's just I just feel when they leave us and they do ok but when we do get rid of the drugs and stuff like that – where do they go to?'* (Hilda, Project Worker).

*'And I think that is a big problem – where do they go to because what happens – when people have nowhere to go and they have nothing positive when they leave and if they're not educated or not being given the proper – where do they go? It's proper after care – really good after care.'* (Josephine, Community Representative).

*'We do a form of a wrap-around we try and get them into education (but) you can't cover everything. You can't cover their accommodation, you can't cover their education – you try do your best.'* (Hilda, Project Worker).

#### *5.3a (iii) Mental Health*

The majority (n=6) of participants expressed concern about the lack of mental health facilities for people with substance misuse issues.

*'The amount of people that is coming now are not coming forward with just addiction or poly use drug use – they're coming together with dual diagnosis ... bipolar, personality disorders, depression and anxiety when and they're going to their doctors and just being put up on their anti-psychotic medication – they can't string words together and all you're trying to do is give them a room where they can put their head down for an hour in order to let the medication wear off. These are women with children.'* (Karen, Community Representative).

*'There's a lot of service users that have both addiction and mental health problems – there's a lot of depression and they're either getting treated for one and the other leads you back to addiction ... so then you're going around in a circle and then you're left on medication that you don't need for the rest of your life'.* (Josephine, Community Representative).

*'Our young kids that's coming in the door – the majority have dual diagnosis. Really you know – you could be looking at the weed, you could be looking at the tablets first but it's really the dual diagnosis.'* (Hilda, Project Worker).

*'And then they get themselves to a service like you have to be in that catchment area – you have to have an address in it like – there's not an awful lot of mental health services around.'* (Josephine, Community Representative).

#### *5.3a (iv) Interagency Co-operation*

Lack of Inter-Agency co-operation was a thread in all of the discussions on drug trends, treatment choices, housing and mental health for more than half of the participants (n=5). Of particular concern was the lack of co-ordination between the main housing body in the area, Dublin City Council (DCC), the Community Policing Forum (CPF) and the Gardaí.

*'For me what the CPF did was held everybody responsible for their work and what they're supposed to do – there was local people involved, there's Guards involved there's DCC involved.'* (Josephine, Community Representative).

*'I think there's lots of people that don't take responsibility (and) when they do take responsibility there's no feedback. I think DCC have to take responsibility that – a bit like when people are being intimidated or people are selling that they need to act on these people – they're their tenants – not all the time but a lot of the time. It's everybody responding together or working together. It's not one individuals' fault – it's going on a long time now and it hasn't got better, it's got worse.'* (Hilda, Project Worker).

*'The DCC they will...say to you – well you will have to ring the police first so they'll put it back on the police and not do anything – and again intimidation and anti-social behaviour even when they do report it they just say ring the police.'* (Josephine, Community Representative).

*'It goes back and forward– it's so frustrating for tenants – they give up.'* (Adrienne, Development Worker).

#### *5.3b Social Barriers to Service Engagement*

##### *5.3b (i) Housing and Homelessness*

Two issues around housing were raised. The first one was the issue of intimidation in local authority housing and the lack of a consistent response to anti-social behaviour and drug dealing in some areas. The second issue was that of the level of discrimination experienced by, in particular, single substance users who were in recovery.

*'There's huge problems with anti-social behaviour, drug dealing, they feel abandoned by the State by the Council – the lack of response and they are trying to come forward and trying to give information they're coming up against all barriers – there's kind of you know where they're going "Oh yeah, we're getting an exclusion order" and weeks later this person is still making money and causing havoc in the complex for tenants, intimidation is desperate – fear of repercussions.'* (Roisin, Development Worker).

*'It's very disheartening living in that kind of chaos.'* (Adrienne, Development Worker).

### *5.3b (ii) Discrimination in Housing Allocation*

Community Representatives also talked about the problem of sourcing appropriate accommodation with a history of prior substance use and that lack of support can lead to isolation and relapse in substance use.

*'To get on the HAP (Housing Assistance Payment) ...it's very difficult even if you're a single person and working full time and on HAP...and what's happening is essentially discrimination because if you're a drug user or you're in any way not seen to be the perfect tenant it's very difficult to get accommodation ... if you're a single parent or you're stable on drugs or you have an addiction immediately that's...discriminated against.'* (Roisin, Development Worker).

*'In the bands there's nowhere for a single person and a lot of women are stuck in domestic violent relationships, abusive relationships due to the fact that they don't want to become homeless and the Gardaí – nor the DCC – don't take that as serious – you're not a priority if you're in this violent relationship.'* (Karen, Community Representative).

*'There needs to be a specific person in local authorities that gets a list of available properties to help and facilitate people going to viewing where landlords will specifically take HAP.'* (Roisin, Development Worker).

*'You have service users that get stable ... being sent to a recovery house for 6 months and then put into HAP accommodation in an area where they have no supports they have no one out there. They're isolated, they can't even build relationships with their families their kids, – they're left there with nothing and then cannot be housed by DCC to gain everything back in their lives.'* (Josephine, Community Representative).

*'People who are in the process of being drug free...what's happening is if you can't get accommodation you're back in the homeless services – none of the homeless services are drug free.'* (Roisin, Development Worker).

*'When people go in and they get drug free, I think a supported lodging has to be that they go in and see how they do and then they should be made priority ... (and if they slip) they can come back where they went in for their treatment so in other words instead of them going back on the street if they have – a slip – that they go back a step - they will need supported lodging I think it's too hard for them to come out after treatment.'* (Hilda, Project Worker).

### 5.3b (ii) Drug Related Intimidation and Policing

Efforts at community level to tackle Drug Related Intimidation, discussed by the majority (n=6) of the Community Representatives involved trying to get a consistent approach to open drug dealing and anti-social behaviour in the area and some level of forward planning.

*'People are afraid to go out in the mornings – they're afraid to let their kids out to play – they're afraid to be seen talking to you. I know some tenants have me in their phones under a different name because they don't want to be seen making the connection – they set up meetings to give them a safe place to talk and they don't come in together – they don't want to be seen meeting each other – like it's unbelievable – people would never believe the level of intimidation that people live in on a daily basis.'*

*'The police – there's very little police out but (when something happens) you had five cars and a van out ..."you only come when something happens" and when something serious happens maybe (they) put something in for a while and then take it back out. (There's no) planning ahead.'* (Adrienne, Development Worker).

The majority (n=6) of the Community Representatives expressed a belief that the approach from the Gardaí with regards to drug-dealing is one of containment and that, because the area is not a regular thoroughfare, drug dealing and anti-social behaviour is not on view to anyone not from the area.

*'The way that the Guards are dealing with it is containment.'* (Adrienne, Development Worker).

There was agreement from all attending the interview.

*'That might sound all well and good – it's all in one space but there's families living there – and they're caught in the chaos of it.'* (Adrienne, Development Worker).

There was also concern expressed at the lack of consistency of response from the Gardaí.

*'We got extra Guards and... it was working for a while ...hey'll come around ... but we're not a priority – they do come down and do what they can and what they're told to do but we're not a priority – we're not a boardwalk where people will see us.'* (Hilda, Project Worker).

*'We need...more presence – more visibility in areas ... places where the gangs are coming together... intimidating people that's living in their houses that won't come out .The amount of people ... that wants to move out of beautiful apartments – and I've been in them they're absolutely stunning and people want to get out of them because of the gangs that's there all through the night and all through the day .' (Karen, Community Representative).*

### 5.3b (iii) A Fragmented Community

There was considerable discourse on the effects of substance misuse and its consequent drug related intimidation affecting the entire area, and a sense of a once strong community being fractured by these issues and the lack of a consistent response.

*'At the moment the community has been fragmented, it's been torn apart – relationships aren't there – people are afraid to knock into their neighbour for a bit of sugar people are afraid to talk to somebody – you're very suspicious of someone walking in the area that you don't really know.'* (Roisin, Development Worker).



*'There's an attitude problem (from policy makers) – they look at it like it's like these communities deserve this because it's the same mind-set that thought this community deserved poverty and lack of opportunity and no work or no education – probably it's just another way of leaving it in the community – literally.'* (Glenn Project Worker).

*'If we're wanting to combat that intimidation I think the most important thing is to bring that cohesion back you know because dealing with that individually like if you're getting intimidated at your door ... but if you have a whole street standing up to people – being like – 'no – we're not accepting this.'* (Roisin, Development Worker).

In order to achieve any movement forward the participants felt that the community voice needed to be listened to and that there needed to be a recognition of the shared, lived knowledge and expertise of those within that community.

*'And listening – listening to the community – I don't think that the community voice is properly considered I think that like authoritative public bodies tend to just really overlook that knowledge – there's that division between professional knowledge and then real lived experience.'* (Roisin, Development Worker).

### 5.3c Moving Forward

A suggestion discussed during the focus group interview was to establish community-based hubs which would be staffed by peer-workers from within the community as well as professionals.

The Community Representatives felt that an 'Addiction Hub' located within the community would solve a lot of issues around service provision and access to services and that a link-up between mental health and addiction could be served by a separate 'Dual Diagnosis/Mental Health Hub'.

#### 5.3c (i) Addiction/Community Hub

*'There's no Addiction Hub and that's exactly what that Primary Health Care Centre could be up there. An Addiction Hub where somebody goes and gets assessed - tablets, cocaine, crack and then they're asked what would you like to do? Do you want to go into treatment, do you want to go on methadone, do you want to go on suboxone – but with a plan. The PCC (Primary Care Centre) centre ... because you could be going in there for anything so it's not 'oh they're going in the Addiction Hub' because the Addiction Hub is only probably one section.'* (Karen, Community Representative).

*'A Hub where ... all the links would be there.'* (Glenn, Project Worker).

*'And that would be a good idea as well because that's also a doctors service so if you had a Hub...in there you would have a link in with GPs as well and all in the one building (otherwise) you're getting sent to so many different organisations – you're getting confused and you're not getting the answers that you need and then you give up.'* (Josephine, Community Representative).

Many felt that this should be embedded in the community and involve family and peer-workers in supporting 'recovery'.

*'(It should) be driven by peers because what is huge for making effective change is peers that has either gone through or been through it but not peers ... doing it voluntary – peers getting paid – because you know what? Everybody deserves a wage or something in their pocket – too many times people are asked to do stuff for nothing and that's how the community sector is always kind of falling behind cause its relying on voluntary work for the majority.'* (Karen, Community Representative).

*'(Manned by) the people in the community who are on the ground who are feeling these problems themselves and who have got their kids and other affected by it who want to do something about it because this ... it isn't going to be solved unless something drastic is done. I think if there was a lot more care and that given to the community and that a role and responsibility to working the community back together ... the community has to be imbedded in it.'* (Glenn, Project Worker).

*'If it was ran properly with multi-disciplinary teams including peers and community ... a mixture (some service providers) ... even if they were included in there doing talks ...and addiction could be somebody coming in with alcoholism addiction, somebody coming in with prescription tablets, it's not always heroin cocaine or weed – there's a lot of addictions out there that is not being addressed.'* (Karen, Community Representative).

*'Something like that could work – but not for everybody – but it could be accessible if it was done properly.'* (Josephine, Community Representative).

They also talked about the need for support services outside of hours.

*'(At the moment) if someone is in a service ...which is nine to five and they clock off and someone at ten o'clock at night is demented and they're sitting at home with a four year old – and they're not going to pick up the phone because that service is closed but if they have a peer led worker someone they know that has said to them "I know where you're at – there's my number ring me." And sometimes it's only sometimes – they kind of need to just you know they just need someone to blow off a bit of steam – someone to say "right, yeah."'* (Josephine, Community Representative).

*'That's where the work addresses a lot of these small issues – that become bigger – the fact that there is somewhere to actually go with your crap. There's somewhere that actually cares because otherwise...they're going to six, seven eight nine appointments and you give up. Because at the end of it it's the same old nonsense and you can start all over (and some service users say) I just want treatment. I want out of this life.'* (Glenn, Project Worker).

### 5.3c (ii) Dual Diagnosis Hub

It was felt that the 'Addiction Hub' idea could be expanded to overcome the difficulty of dual diagnosis when a service user presented with both addiction and mental health issues.

*'And that's why I think the Dual Diagnosis Hub has to be trained in that as well and not only that psychiatric nurses and that but peers that has gone through ... between the Addiction Hub and the Dual Diagnosis hubs ... they're two completely different Hubs.'* (Karen, Community Representative).

*'It has to be peer led because it's a subject matter that they understand they've been through the pitfalls they – not on their own there's always support networks but it has to come that way.'* (Glenn, Project Worker).

*'There's a model that the HSE use with mental health peer workers and I think that would be the ideal one to follow because there's someone that gets specific training to do that work and there's different levels of it - people with degrees and people not with degrees because going to university is not for everybody – but that doesn't mean that somebody without a degree hasn't got the capability or the experience.'* (Karen, Community Representative).

## *Summary of Community Representative Findings*

### **Systemic Barriers to Service Provision and Engagement**

*Poly-substance misuse and inapt treatment criteria*

*Care planning not embedded*

*Insufficient treatment choice*

*Inadequate addiction/mental health dual diagnosis approach*

*Poor Inter-Agency co-operation*

### **Social Issues around Provision and Engagement**

*Homelessness, housing supports and discrimination*

*Drug related intimidation and policing*

*The fragmentation of a community*

### **Moving Forward**

*Community Response – Community Treatment Hubs*

## 5.4 Family Findings

This section reviews the findings from family members who are both living in the NEIC area and have a relative (either at the time of the study or in the past) experiencing substance use issues. Eight family members were interviewed for this section of the study.

### 5.4a Systemic Barriers to Service Engagement

#### 5.4a (i) Drug Use Trends and Access to Services

All eight of the family participants were concerned at the level of poly-substance use amongst their relatives, particularly as it acted as a barrier to accessing services.

*'You name it – he'll take it.'* (Marie, aged 55-59 years).

*'The mix as well – the tablets and the drink, or the phy\* and the drink – they don't know what's going into them. They take sheets (of tablets) ... they black out – they can't remember anything. And they (service providers) are very 'this is your methadone group, and this is your – and most people are now on phy, tablets, drink – whatever – and (in one support group) people who weren't on methadone even though they were on gear couldn't get help.'* (Olwen, aged 30-34 years).

*'Don't be talking – they do say – what age, what is he taking and no sure we can't take him. Did you try such a place – it's the – yeah there are barriers there in a lot of the places. It shouldn't matter what you're on – if they're presenting somewhere for treatment.'* (Anna, aged 65-69 years).

They also talked about the inaccessibility of simple treatment pathways for substance misusers who want to come into recovery.

*'You have to come up through that whole system – you have to ring them everyday – you know you could be really determined one day – and then you have to ring and you have to do the assessment and then you have to keep ringing every morning – the person has to ring themselves that's on the drugs that's looking for treatment?'*

*'To be able to walk in somewhere and get an appointment there and then speak to someone immediately to relieve people's fears and give them an appointment – one that wouldn't be too far away from the time that they presented. Easy access to services I think that's a major thing.'* (Anna, aged 65-69 years).

However, the participants also noted that it is difficult to seek help if the family member is experiencing chaotic substance misuse or simply are not ready for help.

*'They did know where to get help but just didn't want help.'* (Evelyn, aged 40-44 years).

*'He's just oblivious to everything you know ... it's finding it hard for him to go get the help – that's the problem. He'll say 'yeah I'll be back' and then he wouldn't so it's more himself.'* (Marie, aged 55-59 years).

Marie talks about feeling relieved when her son is in prison as his substance misuse is less chaotic but equally that there is no real help there for him.

*'Unfortunately it is probably sounds bad to say but I'm actually relieved that I know where he is cause he's a young fella that he'll go out there and he goes missing...see when he's in there he's on his medicine – that's what I call it the medicine, the phy and he's eating – he's sleeping. I'm sure they can get drugs in prison but he wouldn't be as bad in prison if that makes sense? So he's more stable.'*

\* Phy refers to Physeptone, the first version of heroin substitution treatment with later became methadone. However, methadone is still referred to as 'phy' by substance users and their families.

But she also points to the lack of services in the Prison system: *'I feel that see when they go into prison (there should be) two doors – and look do you want to go in the cell or do you go into the treatment centre.'* (Marie, aged 55-59 years).

They all talked of the need for more information around treatment options and supports.

*'Maybe if the clinics let you know more about different services that is going and stuff like (but) I didn't really have a clue what was around.'* (Olwen, aged 30-34 years).

*'I wouldn't have had a clue — his father was an addict and I used to think (child) was smoking hash and I'd say ah alright – I hadn't a notion – I didn't have a clue but I knew something was wrong if that makes sense. And I would have been very ashamed and embarrassed. It's the stigma of 'Jesus – what will people think of me my son is on drugs'. (Marie, aged 55-59 years).*

#### 5.4a (ii) Drugs and Alcohol

Three of the eight family members felt that alcohol misuse has been normalised and was adding to the problems of aggression, especially when combined with poly-substance use.

*'I think (alcohol) is ignored a lot and has been normalised a lot, whereas with other things 'Oh Jesus, he's on that or she's on this' but if someone is out gargling you know in an awful state it's just not seen as serious as taking gear or on the phy. The mix as well – the tablets and the drink or the phy and the drink.'* (Olwen, aged 30-34 years).

*'Or phy like but I see it with me own (child) ... going crazy like you know? It's the drink that gets him gaga you know. Blacking out – he's locked up because of the drink – its more the drink than the drugs. Nowadays where they're on the phy and the tablets and then they're drinking they're going fucking crazy – they're going mental.'*

*'And my (relatives) ... were never aggressive to me mother and my father – them days you didn't know what heroin was or anything like that but they were – I can't remember the house being chaotic with madness all that stuff because they didn't drink when they were on the heroin.'* (Marie, aged 55-59 years).

#### 5.4a (iii) Care Planning

Family participants who had relatives in methadone maintenance treatment expressed concern about the lack of care planning and input into treatment decisions.

*'I don't think it was ever meant to be long term (there's) people on (MMT) now over 20 years ...now I'm not saying everyone should come off it – everyone shouldn't – but there's a huge amount and you're not given an option to come off it.'* (Olwen, aged 30-34 years).

*'I remember going into the clinic with my son then and he was young then ... and like that he was in a bad way from the heroin and all ... but it was more the drink and tablets - grand they put him on whatever so many mls and after a while I went ... and I actually had an argument with the doctor ... they had him on 90mls and I said 'He's only a young fella and you have him on 90mls' because ... they'd say 30mls would hold a horse. So why are they putting these children up to 90mls if 30mls would hold a horse. Does that make sense? 90mls. And then the drink on top.'* (Marie, aged 55-59 years).

#### 5.4a (iv) Mental Health

Half of the participants who had tried to get help for their relatives who were experiencing mental health difficulties as well as substance misuse issues found it impossible to access help.

*'My (child) died by suicide. Because he was on drugs he couldn't gain access to mental health services – in the week he died there were about nine or ten other deaths from drug use in this area in the whole North Inner City.'* (Anna, aged 65-69 years).

*'Mental health and addiction – it's (a huge gap). Huge. It's kind of you're getting sent to mental health services and they're saying we won't deal with you because you're on stuff and then you're getting sent to addiction services and they're saying no – you've mental health issues. You're ... getting bounced between places. It's very black and white in the services. You're either clean or you're not and they include anti-depressants in that ... it leaves a lot of people stuck – just stuck not really knowing where to go.'* (Olwen, aged 30-34 years).

#### 5.4a (v) Interagency Cooperation

Lack of linked up services was of concern to all of the participants in the areas of mental health, housing and policing.

*'I don't think there's a huge crossover with it or a huge communication with the mental health and the addiction services really.'* (Olwen, aged 30-34 years).

Rosaleen talked about a bridge that had been built in the area, without consultation from DCC (Dublin City Council), which had brought additional anti-social behaviour into the area as well as a number of rough sleepers.

*'DCC (is) going ahead with plans without consulting and that's not the only one but that's a great example. They have this new approach the last year where they're just going ahead and not talking to the residents (so now that bridge) gets used as a dumping site, there's spray painting and it's used for rough sleeping ... it's brought mayhem. They want to know all this – what can we change. When are you ever going to sit down with us and ask us?'* (Rosaleen, aged 40-44 years).

#### 5.4b Social Issues around Service Engagement

##### 5.4b (i) Housing and Homelessness

Almost all (n=7) family participants had a history of housing instability and talked of the length of time on housing waiting lists.

Eleanor, who moved to the NEIC to get away from a difficult situation in another part of the country found herself in a relationship marked by drug-related violence and had to leave that accommodation. She and her young child spent many years couch-surfing and in hotels while waiting on safe, secure accommodation.

*'There was no availability in refuges and I suppose kind of I felt more for my child was unstable which obviously would affect education, she wouldn't know where we were going from one day to the next.'* (Eleanor, aged 30-34 years).

She felt that the lack of supports for women in experiencing domestic violence leave them more vulnerable: *'They actually put me at more risk with no supports – (it was) the criteria. You have to be homeless or hand back your keys if you hand back your keys you're two years frozen on the list you're not even looked at and you have to self-accommodate.'*

Other participants talked about the insecurity of private rented accommodation.

Marie, who is on a waiting list for 13 years explains that she has moved continuously throughout her life: *'I was in a different apartment in the NEIC area and like that I had to move out of that and – I've moved around a lot myself yeah.*

[Like more than 5 or 6 times?]

*'Ah do you know what I'll have to sit down one day and actually write down because I'd say it was 50 odd times – a lot.'* (Marie, aged 55-59 years).

Another participant, who had recently experienced the loss of a family member through substance misuse had been told on the day of interview that she had to vacate her rented apartment.

*'I'm waiting to be kicked out. I'm on the RAS (Rent Allowance Supplement – replaced by HAP) as well. (The landlord says she's selling up but I don't think so - I think she's just going to put the rent up. I was there four years and before that in a house in (NEIC) and the same thing happened. I was there for 9 years.'* (Evelyn, aged 35-39 years).

Evelyn is on the waiting list for 18 years. She explained that she went to DCC regularly to find out if accommodation would soon become available to her. *'They told me a few weeks ago to stop going on at them.'* (Evelyn, aged 35-39 years).

*'I can't wait to get my own place you know? I'm sick of renting and – yet I do be saying to myself no Marie just count your blessings you're not bleeding homeless you have a roof over your head.'* (Marie, 55-59 years).

Marie, has a relative in the same situation, but with children and talked of the lack of supports for women with children: *'She's in a place in a B and B place she's there a year and a half – she actually has (a child with) autism and – they have offered her a house out in Finglas but she won't go out that far ... because she will have no supports.'*

Older family participants were more likely to have stable accommodation in terms of long-term tenancy from Dublin City Council (DCC). However, as the participants pointed out, stable housing did not necessarily equate with safe housing.

*'I don't know if it's a stable environment we live in never mind stable housing. I live there with my husband and two of us work. I suppose it's the environment more around me that would be very unstable.'* (Rosaleen, aged 40-44 years).

*'Not even a year ago ... one of the gangland shootings was done outside the door where I lived. And I seen everything – when you look out my window (flats) I witnessed all this intimidation within the complex – you knew they were selling – that would have lived in the flats so you'd see them coming around the back and buying this and buying that.'* (Orla, aged 45-49 years).

There is a shared feeling that the Gardaí are containing selling in the NEIC area.

*'It is containment in that they do go in and police an area really well and then it's moved. There (are CCTV) cameras – but they're not working.'* (Rosaleen, aged 40-44 years).

*'With the cameras on all around where I live they're – not one of them were working. There was no CCTV. And they offer security in that area and it's there and the security man if you ring about an incident all you get told is can you ring the guards he doesn't even come out to see – you're getting told there's security in an apartment complex but then what is that?' (Eleanor, 30-34 years).*



#### 5.4b (ii) Drug Related Intimidation

More than half of the participants (n=5) talked about drug related intimidation and drug debt, which had created an atmosphere of fear.

*'People won't get out on the streets they're just afraid. Not like they did years ago – no terrified. Too easy to get guns and everything else. I tried the approach of saying (something) once to a neighbour and it didn't go down too well so I've learned to not say anything. Because windows can come in on top of you ... and it's quite dangerous living in the area and trying to be vocal on some of the issues.'* (Rosaleen, aged 40-44 years).

They talked of the problem of drug debt for family members, who were trying to clear one relative's debts: *'In the meantime between the dealers ... were after shooting at his house they were threatening to do violent disgusting things to his girlfriend threatening his child so there was a lot of intimidation over the drug money that he owed ...that went on over a two and a half year period. And then he was shot in a raid that he was forced to carry out to fulfil the remainder of his debts.'* (Anna, aged 65-69 years).

*'There's a few kids where I live would have been caught up in addiction ... not even a year ago where one of the gangland shootings was done outside the door where I lived. And I seen everything. When you look out my window (flats) I witnessed all this intimidation within the ... so they're dealing out the back of the flats ... see the old people where I live? They're terrified they can't open their mouths. I'm a little bit younger and I wouldn't say anything. They definitely wouldn't say anything.'* (Orla, aged 40-44 years).

*'And it's intimidation in itself. Especially if you're elderly or living at your house and you have that going on. They're 16 year old lads full of testosterone ... full of anger.'* (Rosaleen, aged 40-44 years).

Drug Related intimidation is not confined to residents who are involved in the drugs market in the NEIC. One participant talked of a resident whose son had merely witnessed an incident in the area.

*'This ... mother is just gone through it. And they've climbed up on her window and knocked on her window and waved at her ... total intimidation. And they're driving by her and blaring the radio or stopping and just staring. He witnessed something but even down to that's how bad it is. Even if you witness something you can be targeted.'*

*'He wasn't ... linked up in their feud directly but he witnessed something and now they're after him ... so we had to get that young fella out of Dublin and you'd want to see the job to get him out of Dublin ... everybody is involved but there's nobody (taking responsibility).'* (Rosaleen, aged 40-44 years).

She describes being bounced between DCC, the Gardaí and the DSP.

*'(We need a) person that's linked in with DCC and DSP so if you need to get a family out of the county so that things like housing or welfare or their payments will move with them because (the last few incidences) they were turned around back from different counties – "no we can't pay you – go back up to Dublin – where's your proof of address?" Where if you had a letter to state that this person if they called the code or whatever as least the DSP would know but there's nobody there to help you with all that.'* (Rosaleen, aged early 40s).

*'So it's all well and good taking the person out of it but then they have another fight on their hands in trying to get paid, getting housed.'* (Orla, aged 44-49 years).

Fear of retaliation or being targeted can lead people to leaving their homes to pay a relative's drug debts.

*'(People) will not speak to the Guards will not have any connection with because their fear of identity their fear of being seen talking to them. (And having paid debts) they've got their lives back on track to a certain level even though they're in hotels over it. But people are crying out for the help.'* (Anna, aged 65-69 years).

*'There's people selling their own houses – that own their houses ... there was a message put through her door going 'I know the window that your daughter sleeps in and if this isn't paid ... and she's after having to sell her property up to but still it's not even enough(to pay the debt) and she's had to leave completely. She wanted to take her son with her and the son is still here ... it doesn't matter where you go – they have connections everywhere – they're going to find you...and he was like "No Ma if I'm going to die it's my own fault for getting involved and it's one way in and it's no way out."* (Eleanor, 40-44 years).

Participants also talked about the work of the Community Policing Forum (CPF).

*'The CPF is good for that. It wasn't official, it was more informal and that worked but again for a family when it's with the feuds and all (people) just won't go to CPF and then the CPF hands are tied (anyway) they can't do anything. They can report it to the Gardai but that's it.'* (Rosaleen, aged 40-44 years).

Drug debt and death through drug violence and or accidental overdose leaves families financially vulnerable - both paying their family members' residual drug debt and in many cases also minding their children as well.

*'I have a friend (who was in) part time work. Now she's in full time work – her partner is in full time job and (working) weekends and in the evenings to pay for her son's debt – I think its twenty odd grand. Her windows was put through – she doesn't go out because every piece of money she gets is going to pay his drug debt and he doesn't even live there.'* (Orla, aged 45-49 years).

*'(A mother whose son died) ... left with her grandchildren and minding her grandchildren – now she was only in her late 40s herself – now she's rearing a second family all due to this and that was all over – I think it was 500 euro for cannabis or something – when you think of debts you know?'* (Rosaleen, aged 40-44 years).

*'My son was killed over the drugs. I have no one to help me with the kids. At Christmas now I have to take two weeks off because there's no one else to mind them and I don't get paid for that so I get behind with the bills.. I get an extra 21 euro for the other grandchild from social welfare – and the bereavement grant – it was inhuman – I was back and forward ...you're just left standing on your own. You're like all over the place with grief and then there's the kids. Some people go out and get jobs – instead there's feuds – families – all involved in drugs. I get very angry and frustrated.'* (Eimear, aged 45-49 years).

*'What they're putting up with on a daily basis and struggling and even cutting back – they've no bleeding messages this week because every penny is after going on paying for the debt. Even down to the parents – sometimes they might even be drinking heavier like because of the situation that they're in. They might ... escape in an unhealthy way. If they're living in the area how are they going to cope seeing every day – that fucking bastard I'm paying – I'm giving you money and I'm out working 7 days a week because my son owes you money.'* (Orla, aged 45-49 years).

#### *5.4b (iii) Family Supports*

When talking of family supports, five of the eight participants have a problem accessing services for fear of intimidation and note that family support around this issue would need to re-named and comprise a number of elements – drop in, outreach and phone support.

*'We would have a lot of people in this community you know - cousins on both sides of that feud and for them to even walk around the streets its always tension.'* (Rosaleen, aged 40-44 years).

*'I think if there was a location where they went to but if you dressed it up like it's for drug related intimidation then that place is going to get watched ... (whereas you could not label a family support as being connected to drug related intimidation)..maybe you could call (it a) social gathering ... and maybe it could be things like respite being offered to families you know – because they constantly have people banging down their doors looking for money and they're working all the hours that God sends them for them families. You'd have to change the whole language of it.'* (Rosaleen, aged 40-44 years).

*'It's not just about someone going to a service – it's to have that phone call or where you can say – you can sit down and have a cup of tea – space for you because they could be with others that are caught up with it going to the same place.'* (Orla, aged 45-49 years).

*'Even a phone call would be something so that you could tell them what's going on. There's days I'm full of anger at the system - they just don't care at all.'* (Eimear, aged 45-49 years).

#### *5.4b (iv) Children and Young People*

Five of the participants talked of both drug initiation and dealing as happening at a young age.

*'They're ... looking at their older siblings starting drugs when they're 14, 15. And you see a lot of them down here were dealing because ... now they're seeing that so they're making a few bob and going out and buying you know. What they could have if they were only selling a bit of hash – but no one ever sells just a bit of hash.'* (Anna, aged 65-69 years).

Rosaleen talked of 'gang grooming' at very young age: *'I'm talking about they would be everything from 15 years upwards and do you know what's even the saddest thing about it, you've seen these kids being groomed since they were 10 and 12 to first carrying and muling and carrying around drugs and knives and guns and now they're standing there dealing.'* (Rosaleen, aged 40-44 years).

*'Kids (are) getting paid money to stand on a bridge to watch out if Guards were going by – like that was the littlest thing... and then it escalates...and then you go up the ladder.'* (Eleanor, aged 30-34 years).

*'Even the drugs that they come out with that's around – you're talking anything from 8 years of age onwards. It's scary to know that it's getting younger.'* (Anna, aged 65-69 years).

#### 5.4c Moving Forward

##### 5.4c (i) Education and Prevention

All of the participants felt that an education and prevention programmes need to be started at primary school level.

*'I think it's most important to get the young people – it needs to be spoken about, it does. I remember but when we were fighting with the teachers – not fighting but saying there should be drugs education in school but they were saying but they do the (SPHE).'* (Anna, aged 65-69 years).

*'You have to bring it to primary school and I know people will probably say that kids don't need to hear that in primary school. Kids already know about it especially around these areas.'* (Rosaleen, aged 40-44 years).

However, they also felt that education and prevention needed to be rolled out to all areas of the community.

*'I think there's a bit more education that needs to go there too and that's that everyone – it is early school children it is teenagers, it is parents men and women it is grandparents – there needs to be more of these awareness groups going on regularly in the community because the more you make that normal – that it's alright to come out and talk about it.'* (Rosaleen, aged 40-44 years).

*'We got education around drugs and things like that – and people – that hadn't experienced drug taking we never took seriously - but someone that's experienced it seems to grasp the kids' attention more because they had told their own experience of what happened ... they're emotional.'* (Eleanor, aged 30-34 years).

##### 5.4c (ii) The Meaning of Recovery and Recovery Capital

Five of the participants talked about recovery, and the difficulty of social integration, especially around employment.

*'The thing about recovery I think the model of recovery that they're using is all or nothing – and you can't have an all or nothing approach. Ok for some people you probably can but ... putting that pressure on someone is not attractive whereas if you do other things ... like from time to time youth that gets involved in different pieces would go and work down for a year or two and maybe they need to extend that and have programmes like that but in Dublin. So if they're into being an entrepreneur find out is it mechanics, is it – there's no apprenticeships or nothing like that.'* (Rosaleen, aged 40-44 years).

*'And there's the other thing about convictions too – so even if you got rid of that drug debt, now you're after ending up with a record – especially in your teenage years that's usually when you go out and do everything for a few bob especially if you're caught up in this. So the barriers are there straight away - in spent convictions. The Irish Prison Reform Trust - what they did around spent convictions – if you get one fine for example – they'll wipe away one fine...'*

*'Who has one fine?' (Orla, aged 45-49 years).*

*'The amount of people with qualifications that can't get work is shocking...and if I was a child and I was looking at (family) with qualifications and they're not even getting jobs ... I'd be thinking if they're after working their ass off and they're not getting what's the point in me doing it?' (Rosaleen, 40-44 years).*

## *Summary of Family Findings*

### **Systemic Barriers to Service Engagement**

*Poly-substance misuse and inapt treatment criteria*

*Absence of alcohol treatment*

*Insufficient treatment choice*

*Inadequate addiction/mental health dual diagnosis approach*

*Poor Inter-Agency co-operation*

### **Social Issues around Service Engagement**

*Homelessness, housing instability and safety*

*Drug related intimidation and policing*

*Absence of family supports*

### **Moving Forward**

*Children and Young People*

*Recovery and Moving Forward*

## 5.5 Service and non-Service User Findings

This section reviews the findings from those experiencing substance misuse in the NEIC. Ten participants were interviewed, and six of these were formally engaged in services in the area. A further two were engaged on an ad hoc basis, dropping in for support when they felt it was needed. A further two participants were not formally engaged in services but had recently been recipients of a local assertive outreach programme.

### 5.5a Systemic Barriers to Service Engagement

#### 5.5a (i) Poly-substance misuse and service engagement

Eight of the ten participants were, (either at the time of the study or in the past) poly-substance users. In all instances, substance misuse had started with a single substance and quickly progressed into poly-substance misuse. Substance use ranged from marijuana, cocaine, crack cocaine, ecstasy, MDMA, Ketamine, Crystal Meth to tablet use. In most instances (n=8), a minimum of four substances were being used at the same time. Less than half (n=4) of the participants had used heroin and at the time of the study, only one participant was using heroin. The majority (n=8) of the ten participants felt that it was difficult to engage with treatment as the criteria did not match their substance use.

*'There might be services but they're not as easy to access. The waiting lists – it's ridiculous – it's all about maintenance – and you have to be taking certain things.'* (Leo, aged 30-35 years).

*'Well for years me life was like a pattern between being locked up in a detox, in A&E - I remember when I picked up the alcohol. I really did try for help but nowhere would help me because I was cross addicted. There's nowhere for cross addiction. For six months (I went) here there everywhere and there was nowhere would take me and at that stage I would have went in anywhere. It was that bad.'* (Sylvia, 55-59 years).

*'I found that this time around with the painkillers and especially OTC (Over the Counter Medication) now I did get treatment for heroin which I haven't touched in over 25 years or so but OTC medication and painkillers that I abused - I tried to get help to get off the (codeine) ... I went down to a treatment centre and they couldn't take me in because there was no doctor there. I tried and went to treatment and I couldn't – fit into a slot. There was no like – this slot that slot. I wasn't fitting into their criteria so I found that extremely hard.'* (Rebecca, aged 40-45 years).

Equally, there was concern that in many instances a prescribed drug was used to help manage substance misuse but that this led to problems with tablet misuse.

*'There is no help. Like I got help here but that was it like – I went into treatment and I got sorted like – the drugs to get off the drugs.'* (Martina, aged 30-34 years).

*'I'm in daily (at the methadone clinic) yeah. I asked me doctor for help to get off the tablets. He says "I'm not your drug dealer – I won't be giving you help like". They're all addictive tablets and now they're trying to get people off.'* (Annemarie, aged 35-39 years).

*'(The doctor) doesn't like to give you a tablet detox he likes getting you in somewhere to get off them – he doesn't like prescribing them like.'* (Sarah, aged 30-34 years).

However, with wait times of a minimum of six months for a bed in a detox unit, and no support for children in their absence this was seen to be an unrealistic approach.

### 5.5a (ii) Drugs and Alcohol

Alcohol was being used, in addition to drugs, by more than two-thirds (n=7) of the respondents. It was felt that alcoholism was normalised and that there was little knowledge of services for alcohol misuse.

*'Drink is just the norm in Dublin, in Ireland - we're Irish we drink so. It's our culture.'* (Sarah, aged 30-34 years).

*'(Alcohol?) ah – it's the worst – I was almost 30 years of using drugs and it was shocking what two years of drinking did to me. Done more damage to me health wise and everything.'* (Sylvia, aged 55-59 years).

*'I actually went on a – little rampage three weeks ago ... and after I was just drinking alcohol – very intoxicated – everything started coming back to me. Blacked out. I woke up in a police station. Me ma said that I tried to stab myself in the house. Just alcohol. Reacted very badly yeah. And I'd never thought that that something like that would happen. Depends on what's going on inside the head.'* (Alan, aged 20-24 years).

*'The drink is kind of like a gateway drug cause if I start drinking that leads to the heavier stuff like coke. Yeah – your nose starts.'* (Robbie, aged 20-24 years).

### 5.5a (iv) Knowledge of services

All ten of the participants stated that they had little awareness of services, and four had engaged in services as a result of statutory referral (n=2) or had been engaged in youth services at a young age (n=2) and returned looking for help. Of the remaining six participants, two had never considered looking for help and were only accessing services as part of an outreach programme being run in the area. The other four had heard of services by word-of-mouth from friends who had attended for intervention or as a result of local knowledge.

Sarah, who had been using heroin only was referred onto methadone maintenance and her children were removed from her care. At the time of the study, she was engaged in a service for that she had found out about from a friend. *'And for one thing you've done wrong like you don't get a chance like – your first mistake and they're (children) gone like. It's not like three strikes and you're out.'* She continued that the clinic she attended did not tell her about this service for women, but that she found out about it from a friend. *'I've been going to the clinic over there a good few years and I never even knew this was here until last year.'* (Sarah, aged 30-34 years).

*'There probably was services there for me but I wouldn't know about them.'* (Niamh, aged 40-41 years).

*'There's not enough advertisement for them.'* (Sarah, aged 30-34 years).

Equally, the participant who was using alcohol only was unaware that it was a service that catered for her. *'I thought it was just for people with drug addictions and I didn't know there was anything got to do with alcohol - I was told then that (service) deals with all addictions so this is how then I started here.'* (Niamh, aged 40-44 years).

Talking about a different service, three participants referred to the value of local knowledge.



*'Well I knew about (service) cause I was born and reared I only live down the road and that I remember the service only opening ... and every day I was saying "I'm going down there for help" but when you're caught up in addiction like it's – the pressure from family to get help but you don't bother because you think you're not ready for it yet ... but I would have attended here for years saying "I want to get clean, I want to get clean."' (Sylvia, aged 50-55 years).*

Robbie and Alan had been linked in with a local Youth Club in the area from an early age, and found the fact of an established, trusted relationship with the staff meant they felt comfortable asking for help.

*'Building a relationship is really, really big. Yeah. Like I went to the (Youth Club) before I even said it to me Ma you know like. If it wasn't for the (Youth Club) probably most people down here would be – still in the gutter you know what I mean.'* (Robbie, aged 20-24 years).

*'Yeah I've been I've been in the (Youth Club) since about – for years. Since I was a nipper.'*

[So that must have been good then to be able to look for help from people you knew?]

*'Yeah.'* (Alan, aged 20-24 years).

Ryan, in receipt of an outreach service, had only started looking for help *'Just about now. I got put through to (service) from a friend of mine.'* (Ryan, aged 30-34 years).

Both Ryan and Leo had spent most of their lives in and out of the criminal justice system from an early age and found that there were no supports for them in juvenile detention or prison, and in Leo's case that the lack of services exacerbated his substance use.

*'Yeah – it wasn't until I was 16 that I went to prison (Juvenile Detention Centre) (you could get) heroin, E's Valium – Valium was the main drug – I had never took a Valium before I went to that prison - not the first time I seen one but definitely the first time I took one. I spent most of my time in a 22 hour lock up in (Juvenile Detention Centre) – so that actually made me worse. If anything – it made me ten times worse.'* (Leo, aged 30-34 years).

#### *5.5a (v) Mental Health*

Mental health was an issue for more than half (n=6) of the ten participants. In some instances, substances were being used as an escape mechanism and in other instances triggered more severe episodes of depression.

*'Just life – just stuff that happens. You want to get more out of your head and what you were using wasn't working so you just moved onto the next thing?'. (Martina, aged 30-34 years).*

*'I know now – at the time escaping from family life. I always I wanted to be out of my house but there was a reason I wanted to be out. I didn't know how to deal with what was going on and when I took (substance) that it was like I could talk to people.'* (Rebecca, aged 40-44 years).

Alan talked about the after-effects of using coke and ecstasy, which he felt he used because of lack of confidence and depression. *'I got (even) more depressed after like it was good at the time to take it - probably not good at the time to take but I was at that age you know to take the drugs – everybody was on them but like I was on the comedown back in my home and I got – got a real bad depression. Got very bad.'*

He spoke about trying to take his own life on the street and being found by a relative with his wrists cut. *'I was on the street. I was ... and they carried me around to the house and then it was after that then me mother that she started finding out that I was doing drugs and that really hit me hard so... so that broke her.'* (Alan, aged 20-24 years).

Equally, Robbie described being very depressed after a family trauma. *'I probably would be dead because the path that I was going through in my head like I was getting suicidal thoughts that's how bad I was. I didn't really care I was just in that phase where I didn't care about anything. I didn't care if I lose my job, didn't care about upsetting me ma or upsetting me friends or whatever. It's like I was just numb for that little period of my life. When I opened my eyes and I seen the bigger picture that's when the shit started hitting the fan.'* (Robbie, aged 20-24 years).

Other participants (n=3) spoke about death by suicide amongst friends or relatives mainly due, they felt, to the lack of services.

*'A friend of mine hung himself while I was (in prison) so – I just think that wouldn't have happened if there had of been more open – more help for him like'* (Ryan, aged 30-34 years).

Rebecca, who used a community-based service to detox from codeine described the counselling support she received as vital. *'I was offered methadone to come off the codeine but they had no doctor and that was the thing it was either methadone or go cold turkey and I went cold turkey and I would have actually hung myself to be honest with you if I hadn't have had the support in here.'* (Rebecca, aged 40-44 years).

#### 5.5a (vi) Treatment Choice

All of the participants felt that they were offered little or no treatment choice.

One participant described being brought to a health centre by her Mother (in the past) and given little options. *'I went over there and you have to give three dirty urines – it's mad - me ma was with me and she was saying "You mean ... to tell me you're sending her out to use heroin?" She said she has to have dirty urines to get (methadone) – or the clinic won't start her.'* (Annemarie, aged 35-39 years).

Ryan felt that at an earlier stage his substance use was so chaotic he would have been incapable of finding help but thought that residential detox would have helped. *'Just – at that stage I don't think I could really help myself I was just out of control I was – hyperactive – just running amok. I think there should be more – there should be more easier ways of getting into residential and ... more ways of doing – getting into places yeah?'* (Ryan, aged 30-34 years).

A number of the participants felt that counselling services had helped to bring them out of a relapse into chaotic substance misuse in a number of instances, often as a result of a loss or trauma, but that this was often not a choice offered by the services.

*'For me when I relapsed like – because I relapse after treatment and their idea for me was to throw me back into treatment and to put me on methadone that was it. And ... it wasn't needed. I wasn't back on it long enough - they just wanted to send me back down to treatment and put me on methadone or whatever else there was nothing else there for me. I just fell off the horse like – I just needed someone to sort – to mind me a little bit to get me back on my feet. But there's nothing much around.'* (Sylvia, aged 50-54 years).

*'I don't want to do the same thing again and relapse and end up in the hospital and have to phone my child to say goodbye to her on the phone because they're putting me into a coma. I don't want to put her through that again. So that's what I mean it's a struggle if I was to relapse and go through a whole system of detox treatment. We need counselling.'* (Rebecca, aged 40-44 years).

*'When I was just started getting bad and went to the (Youth Club) and within two weeks like I was going straight to counselling – so that's one thing like that's what I love about that - it's really fast.'* (Robbie, aged 20-24 years).

*'See this kind of room here (small add on counselling space) like you need like rooms like this – I know this is ... for our ages but like people that's on drugs - on any drug – doesn't matter what drugs – whether it's drugs or alcohol – you need like a little section of where you can go and talk about that – and to the point that if you want to go off the drink or drugs or don't but still have somebody to talk to about it. Walk in services. Even now I come around ... once a week now just to keep me mind and now that I'm off the drink I'm trying to – there's an awful lot of emotion and everything is coming back to me now – the past memory like and I'm trying to like – I want to deal with them. And move on and I've at this stage it feels like I can't and I'm scared that I'm going to fall back into a bad habit. See in this area there's drugs everywhere. You get clean and what else is in place? You have to just live your life but (you) need counselling.'* (Alan, aged 20-24 years).

*'I was after doing me programme and all – they had nothing set up for you after you finish and I walked out like I was a brand new baby. I didn't know how to do anything.'* (Rebecca, aged 40-44 years).

## 5.5b Social Issues around substance misuse

### 5.5b (i) Stigma

More than half (n=6) of the participants talked of stigma around substance misuse, both at a familial and societal level. The issue of stigma arose with the female participants but not the males, who largely did not see their drug use as an issue or felt that it was controlled. Additionally, much of the stigma was described by those attending for MMT.

This stigma was felt by those accessing the methadone clinic, either at the time of the study or in the past.

*'Even kids as well – they're looking at people and saying 'ah junkies' because they see people going to the clinic as well like that.'* (Sarah, aged 30-34 years).

*'Kids hanging around together and they will say that. I hate that word.'* (Annemarie, aged 30-39 years).

Other participants talked of being isolated and stigmatised at family events.

*'Being the outcast – people not wanting you there (at family events).'* (Martina, aged 30-33 years)

*'People don't want you around like – won't even look you in the eye.'* (Sylvia, aged 50-54 years).

Rebecca explains that substance misuse is not a lifestyle choice. *'We're like – we are people that made mistakes – I want to better my life but there has to be things in place to help. We're human beings at the of the day we're not just "ah she's on drugs – it's her own fault, whatever, she made her own choice" – we need support.'* (Rebecca, aged 40-44 years).

### 5.5c Recovery and Moving Forward

All ten participants discussed recovery. For the majority, (n=9) recovery equated to being substance free which brought freedom and normality. They also discussed the concept of social and physical capital in recovery, particularly in relation to family relationships and employment.

*'Like just living a normal day to day life and being able to get out and do things. I can't drive and go out and do what I want to do if I'm drinking. Now that I'm sober I can just get up and go and not worry – "Oh Jesus would there be drink in my system from last night" all this kind of thing like. More freedom.'* (Niamh, aged 40-45 years).

*'And not to have handcuffs like – restrictions. We have liquid handcuffs.'* (Sarah, aged 30 -34 years).

The phrase 'liquid handcuffs' refers to being tied to the routine, often daily, of the methadone clinic, and for Martina and Sylvia, recovery meant freedom from the clinic and the constant grind of trying to source substances.

*'Not having to bleeding get up and go to a clinic every morning and go to – who am I going to rob and am I going to stand out all day looking for gear and am I going to be ripped off.'* (Sylvia, aged 50-54 years).

*'Being able to get up out of the bed and not have to plan out your day of how you're going to get your money together or who you're going to scam or –*

[So it's not driven by looking for drugs?]

*'It's just horrific.'* (Martina, aged 30-34 years).

*'See recovery is not to be on drugs and have the stress of going to clinics and just have a proper family and just sit at the dinner table and ask how their day was in school...talk at the table with them like – good family.'* (Sarah, aged 30 -34 years).

*'Just to wake up – normal family.'* (Annemarie aged 35-39 years).

For those on outreach, recovery simply meant having a normal life. *'Recovery is getting your head together and sorting your life out and just living a sociable life.'* (Ryan, aged 30-34 years).

*'(Recovery is) a happy, healthy lifestyle – drug and crime free.'* (Leo, aged 30-34 years).

Robbie, who uses mostly marijuana at the weekends only, and occasionally cocaine and alcohol, feels that he is in recovery as he can hold down his job and functions well within his family structure and has friendships. However, for three of the participants, recovery equated additionally with employment, which they found impossible due to historic convictions. Two of these participants had returned to adult education to study childcare but were unable to find work.

*'I'm complaining about employment this years like and that – it'd help. If you got that open – I done child care and that. (But convictions) I've a long list of them.'* (Sylvia, aged 50-54 years).

*'Spent convictions – that's another thing – you can't get your record erased. It depends on what it is and (it's just one) Who has one?'* (Martina, aged 30-34 years).

## *Summary of Service User Findings*

### **Systemic Barriers to Service Engagement**

Poly-substance misuse and inapt treatment criteria

Absence of alcohol treatment

Poor knowledge of services

Inadequate mental health services

Lack of treatment choice

### **Social Issues Around Substance Misuse**

Stigma

### **Moving Forward**

The meaning of recovery

## 5.6 What is working well in the NEIC around Substance Use Issues?

In discussion with the participants (from all groups) it emerged that there were a number of areas of service provision that had worked well in response to need, either historically or at the present time.

*'I think maybe there's a shyness about what's working well. There was a really difficult heroin situation in this area and ... through a lot of good combined work that has been managed. It's not wiped out ... but it's being managed really well and ... there's a wealth of knowledge in this area about addiction that didn't exist before.'* (Peter, Community/Voluntary Service Provider).

A newly formed case management outreach team operating in the area also came in for praise. *'That works with a number of (people not engaged in services) and we're going to continue that for another year.'* (Patrick, Cross Section Agency, Senior Stakeholder).

Some agencies which have started to link addiction with health programmes, or addiction with mental health, were seen to be a positive step.

*'We're running a health CE information morning (for people with Hepatitis C) and we're seeing individuals that are coming in that before wouldn't ask for a blood test.'* (Frank, Statutory Agency, Senior Stakeholder).

*'That programme for young people's problem drug use – you have consultant psychiatrists and that's made a big difference in terms of the interventions that are being provided. So that's a nice model. It's a model which could be replicated elsewhere.'* (Patrick, Cross Sector Agency, Senior Stakeholder).

An education bursary has proved useful in helping substance users progress in terms of physical recovery capital. *'The Anna Kelly education bursary – it's helping (service users) move on in education and training and it's really valuable and we have a lot of people from the groundwork that was done 20 years ago – they have been service users, have accessed treatment and gone to college, and are now working in the community. That is huge progress in itself.'* (Karen, Community Representative).

Two of the male service users praised the Youth Club that they had engaged with as pre-teens and during their adolescence, which enabled them to look for help, particularly when in chaotic substance use.

*'I went to (Youth Club) and asked for help and did an 8-week counselling course and since then I've been on the up ever since.'* (Robbie, aged 20-24 years, Service User).

The wrap around service provided to one substance user was, she felt, invaluable.

*'I didn't know how to do anything (service) got me on day programmes, they got me counselling they got me funding to go to college – what they didn't do you could write on an ant's arse to be honest with you.'* (Rebecca, aged 40-44 years, Service User).

Equally, for three of the service users engaging in a community-based programme they felt respected.

*'You feel comfortable coming in.'* (Annemarie, aged 35-39 years).

*'The minute you come in that door – you may not want to come in but you want to come back to it again and again.'* (Sarah, aged 30-34 years).

*'You don't feel out of place or – judged.'* (Niamh, aged 40-44 years).

## 6.0 DISCUSSION

This section discusses the findings of all of the participants involved in this needs analysis. In doing so, it consolidates the data from the various groups interviewed – senior stakeholders, community representatives, service providers as well as those directly affected by substance misuse themselves and their families. This discussion focusses on the issues brought up by the participants, specifically in relation to the Overview in Section 2.

This section is divided according to the findings in Section 5. There were three emergent themes from the data. The first of those can be described as systemic – the systems and policy around substance misuse and how they can act as a barrier to service provision and engagement in the NEIC.

The second theme was on social issues around substance misuse in the NEIC that affect service provision and engagement – housing, the social effects of drug markets as well as family supports.

The third theme presents an overview of the participants views on the meaning of recovery and what moving forward entails.

### 6.1 Systemic Issues

There are many systemic issues evident in the NEIC area which act as a barrier to both service provision and engagement. Many of these failures have arisen as a result of the historic response (or lack of response) by the Government to the first and subsequent ‘heroin epidemics’ in the 1980s and 1990s. Failure to recognise the problem at a policy level left people in the local area demanding a response as the number of deaths rose. The Government acted at a local level in response to these demands, and only looked at formulating policy much later (Dean et al. 1986; EMCDDA 2016 O’Gorman 1998).

#### 6.1a Poly Substance Misuse and Inapt Treatment Criteria

There is a sense that the lack of recognition, at policy level, of drug trends in the NEIC is history repeating itself. The current drugs strategy focusses much of its response on problematic opioid use and places additional funding into OST (Opioid Substitution Treatment) as well as increasing the number of detoxification beds available in the country (Department of Health 2017). Treatment criteria in this instance will continue to be focussed on those with opioid dependence (heroin and tablets in the opiate family). This will have the effect of excluding a large number of people with substance use issues in the NEIC.

The findings here indicate that senior stakeholders, community representatives, service providers and service users - who can be said to have a genuine overview of drug trends in the NEIC – feel that the predominant problem in the area is poly-substance use and admit that in this regard the NEIC may be somewhat unique. Service users and their families equally express distress when trying to access treatment, finding the criteria of the service providers too rigid and exclusionary.



Of the 10 people with a substance use issue interviewed for this study, only two were using a single substance. The others (n=8) had a history or current poly-substance use issue. Treatment thresholds, (or criteria) are devised according to funding streams coming into service providers in the area and appear to have the capacity to respond only to one drug crisis at a time (rise in cocaine, crack cocaine, NPS (New Psychoactive Substances) etc) and sequentially, without prior planning for an overall poly-substance misuse approach.

Furthermore, there is no mention in the drugs strategy of the introduction of stabilisation beds. This describes a service where poly substance users could stabilise, either in a residential setting or as an out-patient until a bed becomes available, allowing them to reduce their use or eliminate one or more substances during a phase of chaotic use. Stabilisation beds are seen by service providers, community representatives and family members as an essential service for the area. The HSE, under a major initiative for the area, has recently announced a funding proposal for the development of a 10 bed stabilisation facility, though at the time of writing it is unclear if this stabilisation represents an expansion of OST services or has a broader remit (See Appendix 1).

### 6.1b Alcohol and Substance Misuse

Alcohol misuse is a well-recognised problem in Ireland with its subsequent mental and physical health harms as well as associated anti-social behaviour (HRB 2014; HRB 2016; Mongan 2016). Most of the respondents across all groups felt that there was a thread of alcohol misuse throughout the lives of the people in the NEIC, and that in many instances people may start with alcohol and move on to other substances, or co-use alcohol and other substances. This is particularly evident in the service user findings where the majority (n=7) of participants use or have used drugs and alcohol. In spite of this, there are no formally funded alcohol treatment services in the NEIC. Policy over the years has failed to link alcohol and drugs misuse until recently, leading to a strategic gap in the creation of services (Department of Health 2009; Department of Health 2017). For the first time, the HSE initiative (referred to above Section 6.1a) for the NEIC area is intending to create a community alcohol service as well as a drug and alcohol response team providing case management to the OST service users in the area (See Appendix 1).

### 6.1c Care Planning and Case Management

Policy on substance misuse issues lies within the remit of the Social Inclusion Unit of the Health Service Executive. While this recognises the need for social re-integration of substance users as part of a recovery capital model, it fails to place the problems of misuse as a health issue (Cloud and Granfield 2008; Mayock, Butler, Hoey 2017). As a result, care planning and case management are not embedded in substance misuse treatment approaches in Ireland.

The new drugs strategy takes into consideration the need for care planning as part of a four-tier approach to substance misuse (Department of Health 2017). However, as many of the service providers have pointed out this is problematic on two fronts. The first is that many service providers have experienced successive cuts to funding that have not been restored. Care planning requires a considerable amount of resources in terms of both time and care for project workers, and it is difficult to see how these aims can be achieved without considerable investment. To that end, the HSE intends to roll out a case management initiative enabling interagency case management (See Appendix 1). This initiative is being carried out in conjunction with the Treatment and Rehabilitation subcommittee of the Task Force whereby all participating agencies will be using a common assessment tool devised by the HSE.



The second issue is the lack of recognition of the skills of the service providers (be they managers or project workers) by medical professionals. This leaves a considerable gap in case management, where the service provider draws up care plans that require the co-operation of a medical professionals but that those plans are not paid due regard.

#### 6.1d Treatment Choice and Awareness of Services

While it is the case that those on (Methadone Maintenance Treatment) MMT feel that it has kept them alive and out of a life of crime, a recent Irish study suggests that those in particular on long term MMT programmes feel ambivalent to the approach, having no say in treatment plans and efforts to move forward (Mayock, Butler, Hoey 2018). This lack of input into treatment options is reflected in this research, with a large number of service users, family members and community representatives feeling that MMT needs to be reviewed. The last full review of MMT was conducted in 2010. Similarly, many of the participants discussed the lack of their input into treatment plans when attending for treatment, especially in a clinical setting.

Evident too amongst the service users and their family members is a lack of awareness of services available. Service users in particular report being very unaware of additional services available to them, even having attended one service for a period of time. Most report availing of services by word-of-mouth, having a friend who is already engaged in a programme. Family members, by and large, report having very limited knowledge on treatment options and pathways to support.

#### 6.1e Historic Service Provision and Engagement in the NEIC

The evolution of services in the NEIC, as already stated, came about on an ad-hoc basis to respond to the 'heroin epidemics' of the 1980s and 1990s. At that time heroin use (especially injecting heroin use) was more common in men than women. The ensuing treatment strategy of harm reduction saw the establishment of satellite clinics providing methadone maintenance treatment (MMT), aimed at both harm reduction and a decrease in criminality brought about by imperative crime. Men generally are twice as likely to experience substance misuse, and the reasons that men and women develop substance dependency differ (Van Etten, Neumark, Anthony 1999).

However, at a Community/Voluntary level in the NEIC it was felt that women, many of whom had children living with them, were more likely to need a comprehensive set of resources to help them. As a result, a specific women's community-based service was set up in the area in the 1990s, and continues its work today focussing on supporting women in treatment for substance misuse in education, training and parenting as well as non-tangible assets such as self-esteem and confidence.

In parallel, and as substance misuse began to become more commonplace in younger people, a separate service was devised for children and young people, which focuses on the same themes but for the 14 to 22 year old age group. However, there is no specific service of this type for men.

Men in addiction tend to be a very vulnerable group, often involved in the criminal justice system, detached from their families and more likely to experience homelessness or housing instability (Mayock, Butler and Hoey 2018). There is no service for men in the NEIC area that focusses on what could be considered to be the essential aspects of recovery capital – re-integration, employment and social skills.

### 6.1f Health and Mental Health

While both health and mental health are subsequent harms of substance misuse, it was mental health that gave rise to the greatest level of concern for all of the participants in the study. Poor mental health co-presenting with addiction is still primarily seen as an addiction issue, and not the primary responsibility of the mental health services in Ireland (Vision for Change 2009; 2015).

However, it is clear that there are much higher levels of poor mental health in those presenting for treatment for alcohol and/or drugs than in the general population (Iro and Connnor 2009; Kamali, Kelly, Gervin et al.2005; Lyne, O'Donoghue, Clancy and O'Gara 2011; Lyne, O'Donoghue, Clancy, Kinsella and O'Gara 2011).

The strategy 'A Vision for Change' was the first major policy document published which focussed on the improvement of mental health services in Ireland as discussed in Section 2.5b (ii) (HSE 2006). It placed the majority of the responsibility for the care of people with addiction issues outside the mental health system but noted that community mental health services should respond to the needs of people with both addiction and serious mental health disorders.

However, in the light of reduced spending on mental health during the economic recession in Ireland, many of the goals in the Vision for Change strategy were not achieved. A review of the strategy, ten years later, reiterated that the major responsibility for care of people with addiction lay outside of the mental health services, but urged much closer working relationships to meet the needs of dual diagnosis. Moving alcohol out of mental health to primary care addiction services without resources impacted on the ability of mental health services to engage with the dual diagnosis issue and referral to services. A review of the original strategy found that specialist community teams, which were to address the complex and severe substance misuse and mental health had not been developed (Mental Health Reform 2015).

The lack of co-ordination between mental health and addiction services is of major concern to those both living with and experiencing substance misuse as well as those tasked with providing services for clients co-presenting. There is a consistent thread throughout the narratives that individuals 'fall between the cracks' and that presenting to one service with dual-diagnosis precludes treatment. In the instance of the service providers, they often do not have the capacity or specialised training to deal with specific mental health issues.

Equally it would appear that the mental health services feel they have no remit to deal with people with addiction issues. This would appear short-sighted at best as some of the narratives from service users and their family members suggest that early intervention for those in recovery (in a phase of chaotic substance use triggered by a personal psychological trauma – a temporary 'slip or relapse') in the form of community-based counselling works well.

### 6.1g Inter-Agency Co-operation

The establishment of the NEIC Programme Implementation Board (PIB), which is working directly with the NIC (North Inner City) Drugs and Alcohol Task Force, has resulted in improved inter-agency and community relationships. However, some of the issues around Inter-Agency co-operation have been highlighted in the discussions above on mental health and care planning. This lack of cohesion, for predominantly historical reasons, permeates across and between all levels of agencies working within the NEIC. It is more markedly felt in the lack of 'addiction awareness' that exists in statutory agencies not directly involved in substance misuse service provision (Departments of Social Protection, Education and Training, Housing etc.) which interact with people in the NEIC who are experiencing substance misuse issues. There are a number of Statutory, NGO, Community/Voluntary and Cross Section service providers (working directly in substance misuse) who have good relationships with each other and the NIC DATF (especially where their ethos is aligned) and these service providers report referring individuals to other agencies when needed and in consideration of the best interests of the person presenting.

However, this breaks down when individuals try to access help for issues that are not directly related to service engagement on substance misuse (housing, social welfare, education, health, mental health, family supports, drug related intimidation). Additionally, there seems to be a considerable gap in the knowledge of addiction issues in such agencies.

### 6.1h Buildings, Facilities and Funding Issues

Five of the six buildings visited for interviews with the service providers in this study were over 150 years old. While every effort was made to make them welcoming by the service providers, they were nonetheless largely unsuitable for provision of these services. Most of them have kitchens situated in the basement, with their main service provision areas on the ground and first floors, while project workers and administrative staff are generally located on the top floors, with narrow stairways. None of the buildings had elevators and most had no wheelchair accessibility. The main entrance to most of these buildings involved negotiating a set of steps, creating difficulty for women who had young children in buggies and prams. It is also difficult to see how a wheelchair user or a person with limited mobility could avail of most of the services given these access limitations.

This lack of investment in facilities can be seen to be a reflection of the reductions in spending generally in the area of substance misuse. All service providers in particular point to the successive funding cuts during the economic recession, with little in the way of the pay restoration levels experienced in other areas. Of concern also is the level of bureaucracy brought about by increased levels of governance and compliance imposed by the Government that is required for funding. This is of particular concern for service providers in the Community/Voluntary and NGO sectors, who are often working to tight budgets and have limited or no access to the skill set needed to meet these requirements and find themselves having to buy in professional services, further reducing their budgets.

## 6.2 Social Issues around Treatment Provision and Engagement

### 6.2a Housing and Homelessness

The issue of housing, homelessness, housing instability and housing safety was discussed by all of the participants in this study. For senior stakeholders and service providers, homelessness acted as the single biggest barrier to treatment and in many instances undermined much of their service provision. For community representatives, the issue of discrimination in housing allocation acted against those with substance misuse issues, shutting them out of housing, especially where HAP (Housing Assistance Payment) was applied. Most (n=14) of the eighteen family members and service users who participated in this study had experienced homelessness and/or housing instability during their lifetime.

Studies indicate that those with substance misuse issues can find themselves homeless as a result of their addiction, and that this can lead to increases in both deliberate self-harm (attempted suicide) and drug related deaths and that additionally, homelessness can lead to greater levels of chaotic substance misuse (Glynn 2016; Glynn et al. 2017). Conversely, those in homeless accommodation may also find themselves misusing substances for the first time as a coping strategy (Merchant's Quay Ireland 2017). The recent HSE Housing First policy initiative (HSE 2018) is working towards providing stable housing solutions, particularly for those with complex health needs, such as those in addiction, and has drawn up an integrated approach to addiction and homelessness services in the NEIC. This approach combines a multi-disciplinary Healthlink team (focussing on a bio-psychosocial model of care) as well as a housing case management team and the development of GP services to support the homeless and other marginalised communities in the area (See Appendix 1).

However, participants pointed out that in instances where a substance user may have received residential rehabilitation or have been stabilised (while in prison for example) they are then returning to the NEIC area with no housing and no wrap-around supports. And while there is temporary hostel-type accommodation available for substance users (with alcohol or drug misuse issues) there is no accommodation of this type available to support people who are drug or alcohol free. Furthermore, service user findings suggest that following residential detox they have very little in the way of day-to-day living skills.

### 6.2b Family Disruption

The disruption to family relationships caused by even one member who has a substance misuse issue is well documented in recent years causing in many instances extreme levels of stress as previously discussed, leading to impacts on the physical and mental health of at least two family members (Section 2.5b). (Copello et al 2010; Duggan, 2007; Orford et al 2010; Rossow and Hauge 2004; Schafer 2011 cited in McDonagh and Reidy 2015; Duggan 2007).

Certainly, this is borne out by the narratives of the community representatives and family members who live with harassment, the fear of violence, theft, debt and loss of income, all of which are linked to their relatives' substance misuse. In a number of cases, death or imprisonment as a result of their addiction leaves family members both bereaved as well as caring for children, often with no support. In many instances inherited drug debt means that in addition they often have to either return to work or increase their working hours to cover that debt. There is also evidence of a co-dependent relationships between substance users and family - with many being unable to move out of the family home and become independent.

Of the service users, four are still living in the family home while two are accessing help in the way of child care from their parents and three have depended on family for care of their children in the past.

While there is access to a national family service in the NEIC area, this is seen to be very limited in terms of reach and support provided due to lack of staffing levels. Up until recently, there was no bereavement counsellor for the area to work with the particular challenges of loss through substance misuse and the many residual problems that it brings (drug debt, child care, funeral costs).

The nature of the most recent feud in the area proves a particular difficulty for family members accessing services. They fear finding themselves in, for example, a group counselling session sitting with family members to whom they owe money, or who have been involved in dealing in the area. Access to the family support service has to be initiated by the family member themselves who may often be incapable of looking for support due to fear, bereavement and simply being overwhelmed with trying to pay debts (both funeral and drug debts) as well as provide care for the child or children of the family member who has died or been imprisoned.

#### 6.2c Drug Related Intimidation and Policing

All of the participants in this study were concerned with the problems associated with drugs markets in the area, most notably drug related intimidation and the effects of the most recent feud. In keeping with other studies, there is a strong sense of menace reported by senior stakeholders, service providers, family members and community representatives (Connolly 2006; Connolly and Buckley 2016; Hourigan 2011) while service users describe the widespread availability of drugs as a particular issue if they are trying to stabilise or become substance free.

This discourse permeates all facets of life in the NEIC area. At a macro level, there is general sense of fear due to the continuous level of violence associated both with feuding and an open drugs market, which has led to a generalised sense of mistrust and loss of community. At a micro level, respondents in the area report a self-imposed restriction of movement, lower levels of social engagement and loss of a communal space. Fear of reprisal is also evident, whether as a result of being seen to access a service or for speaking out.

There is a strong sense, from the community representatives and family members, that there is a deliberate policy of policing 'containment' – that the Gardaí have deliberately allowed open drug dealing in the NEIC area. And while participants talk of the efforts that have been made to help (such as the (CPF) Community Policing Forum) this is not consistent, and it was felt that the CPF has no power to intervene effectively.

While drug related intimidation and policing is not the remit of this study, and there is already an NEIC report and action on this issue (NEIC 2018), it is nonetheless evident that it has wide-reaching consequences in terms of service provision and engagement. Many of the solutions to substance misuse could, under different circumstances, be solved by the creation of drop-in centres and sites for treatment provision. However, service providers and family members are profoundly aware of the acute need to provide a number of outreach services to support individuals without creating a fear of reprisal.

## 6.2d Community Fragmentation

There is a pervasive sense of a once cohesive community ‘fragmenting’ in the discourse of family members and community representatives, and this mirrors the findings of earlier studies that the fear and intimidation associated with open drugs markets have had an ‘insidious and disproportionate’ impact on the area (Connolly and Donovan 2014).

Many of the community representatives who took part in this needs analysis have been involved in trying to help their community since the 1990s. They have a wealth of information about the area and the problems contained within it, and an exhaustive depth of knowledge around the issues facing people in the NEIC. However, they do feel that their voice is often not heard, or that their knowledge is not taken as seriously as that of ‘professionals’.

Both the community representatives and family members feel strongly that there needs to be a recognition of ‘lived knowledge’ and an acceptance that often solutions may come from a non-professional field.

The community representatives in particular point to the fact that, with upskilling, many people in the area would be quite willing to act as ‘peer workers’ and that this may offer a solution to many issues especially around dual diagnosis and treatment engagement.

## 6.2e Children and Young People

A number of issues around children and young people were brought up over the course of this study. Of primary concern to most respondents was the age at which children and young people were being caught up in substance misuse, both as substance users and in being recruited into drugs gangs. Service users reported having great concerns about their own children becoming involved in substance use.

There is acknowledgement of the ‘hidden harms’ of substance misuse by parents on their children and a new strategy document outlines a policy approach to a coherent response to this (Tusla 2019). However, there seems little recognition, at a national or policy level, of the issue of substance misuse and drug gang initiation in children and young people. Certainly, in the narratives of the respondents in this study, across all groups (senior stakeholders, service providers, community representatives, families and service users), there is a very deep felt concern that an entire generation coming up in the NEIC area are groomed into gangs and substance misuse at a very young age – in many instances at primary school level and that in other cases very young children are becoming ‘normalised’ to substance misuse and its associated violence.

The National Drugs Strategy, addressing education and prevention, places an emphasis on school-based interventions, aligned to the SPHE (Social, Personal and Health Education) Programme. It also suggests that out-of-school interventions, such as youth services and family interventions, lie in the remit of the local Alcohol and Drugs Task forces (Department of Health 2016). While the strategy acknowledges that problems of substance misuse occur at a younger age than in previous times, it still focusses on young people who are in their teens.

This raised concerns with all of the participants, with service providers stating that substance misuse is recorded as starting as young as eight or nine years of age, with drug gang grooming (according to community representatives, families and service providers) starting as young as 10 or 12 years of age.

It was acknowledged (by senior stakeholders) that education on issues of substance misuse can be a difficult issue, with a reluctance on the part of schools to introduce such education at primary school level. However, given the level of concern of the participants in this study, there is a very real need to address this issue.

## 6.3 Moving Forward

### 6.3a Education and Prevention

Education and prevention programmes have a role to play in addressing many of the issues around substance misuse and its subsequent harms, certainly in attempting to prevent the recurring cycle of substance misuse intergenerationally in areas such as the NEIC. The NIC DATF is currently developing an initiative in secondary schools based on previous groundwork (NIC DATF 2014; NIC DATF 2018). The policy of education and prevention outlined in the National Drugs Strategy through the education system, youth services and the Drugs Task Forces was welcomed by many, even though all felt it needed to be started at a much younger age. Amongst the ‘hidden harms’ of substance misuse in parents can be the lack of the parents’ ability to engage consistently with supports for their children at a very young age, should they have developmental issues (such as speech and language) and it was felt by service providers that addiction awareness services needed to encompass a ‘cradle to the grave’ approach – from pregnancy to early child care, all the way up to old age and death.

Of equal concern to many of the respondents, however, was the lack of addiction awareness in the agencies and government departments working with service users, family members, young people and children living in the NEIC area. Repeatedly, participants reported receiving little or no supportive response from health services, mental health services, social protection, housing agencies, local police forces as well as Dublin City Council. In many instances, lack of response was due to a failure of Inter-Agency co-operation, but there was a greater sense that it was simply a lack of awareness of the myriad problems around substance misuse, perhaps reflected in the fact that addiction continues to be seen as a criminal rather than a health issue.

### 6.3b The Meaning of Recovery

Across all groups (senior stakeholders, service providers, community representatives, families and service users) there was consensus on the meaning of ‘recovery’ in that it was seen as an individual determination on a point of anything between total abstinence and controlled or managed substance use. However, for the service users themselves, the majority (n=9) equated recovery with being substance free, which they felt would give them freedom to live a normal life.

There was agreement that, in line with the concept of ‘recovery capital’, recovery meant less than dealing with substance misuse on its own, and more about being able to support someone to live a purposeful life. In this sense ‘recovery’ had, it was felt, to encompass the four elements of recovery capital - social (family memberships and ties), physical capital (housing, employment), human capital (skills, health) and cultural capital (linked to social integration) (Cloud and Granfield 2008). Certainly, service users talked of family life and employment as key elements of recovery.

While many of the elements of recovery capital have been discussed in the foregoing sections, the issue of employment for recovering substance users was of concern to most of the participants. In particular, the early criminalisation of young people as a result of involvement in drugs markets (as sellers, movers or holders of drugs) or as drug users translated into a criminal conviction at a young age.

The Irish Penal Reform Trust (IPRT) acknowledges that securing employment and training was essential to break the cycle of recidivism around substance misuse. While repeated calls have led to some reform, it was generally felt that this was insufficient and that it was somewhat pointless to talk of recovery in terms of gainful employment after training if a number of convictions were still held leading to the person being refused Garda clearance – a pre-requisite of employment in many sectors in Ireland (IPRT 2019).



## 7.0 CONCLUSION AND RECOMMENDATIONS

### 7.1 Conclusion

There are a number of barriers to service provision and engagement in the NEIC area. They can be broadly described as either systemic or social barriers. In terms of systemic barriers, many of these emerge as a result of poor or no planning or reactive planning to emergent substance issues in the NEIC, without any genuinely consistent and comprehensive planning. The fact that substance misuse continues to be seen as a criminal activity or a lifestyle choice rather than an illness or health issue has led to a number of failures at policy level to create a joined-up approach to the care of people with substance use issues, their families and their communities.

At a societal level, homelessness, drug related intimidation and the involvement of children and young people in drugs markets reflects the reductive nature of policy, and an inability of Government Departments to act cohesively on these issues. Certainly, on the issue of housing, the approach has been to place the issue in the care of NGOs and Community/Voluntary groups, while concerns around intimidation receive an inconsistent approach. Additionally, there is no concerted effort to mandate education and prevention across all age groups, and in all sectors involved in service provision in the NEIC, be they state or semi-state.

Discussion on recovery in Ireland generally seems to have moved from an abstinence model, and this is reflected in the current National Drugs Strategy. However, gaps in funding, personnel as well as established, consistent links across the agencies that are needed to interact to make a four tier model of care work are largely absent although the recent HSE initiative will go some considerable way towards ameliorating this (See Appendix 1).

### 7.2 Recommendations

There is a clear distinction in the findings section of this study between what can be considered issues that can only be addressed at a national level (approaches to treatment, policy mandates, housing, drug-related intimidation and employment) and those that can be achieved at a local level by the NIC DATF, which is tasked with coordinating the inter-agency and community response to drug and alcohol problems at a local level, in close consultation with the PIB and its structures.

As a result, the following recommendations are presented by those which require national input and those that can be realistically achieved at a local level.

#### 7.3 National Recommendations

##### 7.3a *Overcoming Systemic Barriers to Service Provision and Engagement*

###### Treatment

Reconfigure treatment criteria

Provide and engage service users in real treatment choice – harm reduction and substance free

Inter-Agency Cooperation - establish policy mandate to ensure co-operation between statutory and non-statutory agencies in the NEIC

### *7.3b Overcoming Social Issues around Substance Misuse*

#### Housing

Review HAP for single persons/substance users

Oversight/regulation for private hostel providers

Co-ordinated response to housing safety issues

Drug Related Intimidation

Increased Garda presence on the streets

Streamline reporting between those affected by intimidation, Community Policing Forum and Gardaí

### *7.3c Moving Forward/Recovery*

Review methadone maintenance treatment programme

Address issue of spent convictions to enable employment

### *7.4 Local Recommendations*

#### *7.4a Overcoming Systemic Barriers to Service Provision and Engagement*

Reconfigure treatment criteria

Provide community stabilisation beds

Increase access to detoxification beds

Embed care planning/case management across all services

Appoint psychiatric/psychological/counselling services into existing substance misuse services

Provide drop-in, outreach and phone counselling services for substance users

Create community based alcohol misuse services

Establish community based service for men in addiction

Drop in family support centre and/or outreach

Dedicated family co-ordinator, bereavement counsellor and family advocate

Increase awareness of service engagement options in the area through print/social media

Increase staffing and funding across all services

Provide compliance/governance support or additional funding for service providers

Create or re-locate fit-for-purpose buildings for service provision

#### *7.4b Overcoming Social Issues around Substance Misuse*

##### Housing

- Provision of substance free lodging with support services

- Support Housing First Initiatives at a local level

##### Intimidation

- Support community efforts to provide safe spaces

##### Children and Young People

- Consistent education/prevention strategies across all ages

- Increased access to mental health supports at a young age including developmental and psycho-educational assessments

- Addiction aware child-care

- Provision of child-care places for parents in recovery

- Increase out-of-school services for young people (youth groups, training)

#### *7.4c Moving Forward/Recovery*

Provide wrap-around supports for those in recovery (life skills, training, employment, housing etc)

Create addiction/mental health 'community hubs' in the area with trained peer-workers

Provide addiction awareness training to those involved in service provision in the area (eg ETB, DSP) education providers (pre-school to third level) health and child care workers

#### *7.5 Further Research*

Additional research is needed in the following areas:

- New Communities

- Children and young people engaged in substance misuse

- Housing and Homelessness services for substance users

## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CAMHS	Child and Adolescent Mental Health Service
CE	Community Employment Scheme
CPF	Community Policing Forum
CMHTS	Community Mental Health Teams
CSO	Central Statistics Office
DATF	Drug and Alcohol Task Force
DCC	Dublin City Council
DES	Department of Education and Skills
DHPLG	Department of Housing, Planning and Local Government
DSP	Department of Social Protection
DOH	Department of Health
DJE	Department of Justice and Equality
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESRI	Economic and Social Research Institute
GNDOCB	Garda National Drugs and Organised Crime Bureau
GP	General Practitioner
HAP	Housing Assistance Payment
HIV	Human Immunodeficiency Virus
HRB	Health Research Board
HSE	Health Service Executive
MMT	Methadone Maintenance Treatment
NACD	National Advisory Committee on Drugs
NEIC	North East Inner City
NESC	National Economic Social Council
NIC DATF	North Inner City Drug and Alcohol Task Force
OST	Opioid Substitution Treatment
PIB	Programme Implementation Board
RAS	Rent Assistance Scheme
TUSLA	TUSLA Child and Family Agency

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## APPENDIX 1

### New HSE services to address addiction and homelessness in the North East Inner City

The new services are noted in green shading in the table below. The services will provide an integrated model of care to meet the needs of individuals with multiple and complex needs. A NEIC coordinator post and an admin post to collect and monitor data are also included. The total annual expenditure on the new services is €1.8 million, including €1.3 million provided by the Dept of Rural and Community Development on behalf of the NEIC programme implementation board.

Frontline Service	Target Group	Target Service Users	Model	Staffing	Management
Healthlink Team	Homeless Population Dublin Inner City  (3,940 adults at 30th Sept 2018)	1,773  (assumption that 45% of adult homeless population have problematic drug and alcohol use)	Case Management & Key Working  Focusing on bio- psychosocial model of care	1 Team Leader (PSW)	CHO DNCC
				1 Social Worker (PSW)	Social Inclusion Manager
				1 Occ Therapist	
				1 Physiotherapist	
				1 PHN	
				2 Outreach Worker	
				1 Admin Asst. (Grade III)	
Community Alcohol Service	This service will be headed by a Clinical Lead (GP), who will be supported in the delivery of service by 4 CNS within Primary Care, 2 of whom will be assigned to the NEIC		CNS will assess, plan, implement and evaluate alcohol treatment to the highest professional standards	2 clinical nurse specialists (CNS)	Clinical Lead (GP) Community Alcohol Service
Homeless Case Management Team	Homeless Population Dublin IC Hostels, STA & PEA in DIC (450 beds)	450	Case Management	1 Team Leader	CHO DNCC Social Inclusion Manager
				6 Case Managers	CHO DNCC NEIC Co-ordinator
				1 Admin Ass (G3)	
Stabilisation Programme Residential	Polydrug users, co-morbidity, homeless and socially isolated	100	Partnership with Section 39 agency.  Medical	Pharm, GP, Nurses & Support	AOM CHO DNCC  CHO DNCC NEIC Co-ordinator

<b>Drug &amp; Alcohol Response Team</b>	OST (methadone) Service Users NEIC (NIC at December 2017 = 890)	890	Case Management	1 Team Leader	AOM CHO DNCC
				5 Case Managers	NEIC Co-ordinator
				1 Admin Ass (G3)	CHO DNCC Clinical Lead

## Organisational model







