THE NEW COMMUNITIES STREET DRINKING ASSERTIVE OUTREACH PROJECT

An evaluation of the pilot project
May 2020

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Executive Summary

This report will present the findings of an evaluation of the 'New Communities Street Drinking Assertive Outreach' pilot project. Funded by the South Inner-City Drugs and Alcohol Task Force (SICDATF), the project was delivered by Community Response and the CKU Centre for Counselling and Therapy, aiming to utilise existing service skills and expertise. Other local services, Merchants Quay Ireland and Coolmine, also supported the project. The pilot project was developed in response to a recognised need to strategically address the health needs of street drinkers from new communities and to enable new communities with addiction and mental health issues to access treatment and support services. In addition to the intervention, the project also included an action research component and a specific referral pathway to the CKU service.

The evaluation included a review of literature, a review of assessments conducted during outreach work with 45 participants, and interviews with eight project stakeholders from the five agencies involved in the pilot.

Of the 45 people that the project engaged with, three-quarters were male. Over half in this group had children, but most did not live with their children. Three in ten were sleeping rough, while another third lived in hostels or with family/friends. Almost 70% spoke Polish as their preferred language.

Three-quarters of this group had never been tested for Hep C or did not know if they had been tested. Only one person knew that they had tested positive for Hep C and had undergone treatment. However, the responses to the Hep C questions are inconsistent, possibly indicating a lack of awareness of the infection in this group.

Alcohol (beer and wine) was the drink of choice for three-quarters of this group, followed by cannabis. The aggregate scores on the AUDIT-C assessment are high, indicating that this group are at high risk of alcohol-related harms.

Barriers to accessing services included: stigma and shame, communication barriers, cultural and systematic barriers, lack of awareness of services and lack of stable accommodation. These concur with previous national and international research.

All stakeholders interviewed for this evaluation felt that the model of intervention employed in the pilot was suitable, effective and accepted by the target group. The key strength of the project was the interagency approach that was employed, and the enthusiasm and commitment demonstrated by all stakeholders.

There was a strong recognition among the stakeholders that street drinkers from new communities are a marginalised group, but part of the local community, and that their needs need to be addressed as a human right.

A number of recommendations are provided for overcoming the communication, cultural and structural barriers to accessing services experienced by street drinkers with mostly unstable accommodation. Most of these relate to the reorientation of services to better meet the needs of the members of new communities in the local community; however, it is also recognised that addressing basic needs such as accommodation and physical health are pre-requisites for effectively addressing problem alcohol use.

1 Introduction

1.2 Overview of project and stakeholders

This report will present the findings of an evaluation of the 'New Communities Street Drinking Assertive Outreach' pilot project. Funded by the South Inner-City Drugs and Alcohol Task Force (SICDATF), the project was delivered by Community Response and the CKU Centre for Counselling and Therapy, aiming to utilize existing service skills and expertise. Other local services, Merchants Quay Ireland and Coolmine, also supported the project. The pilot project was developed in response to a recognised need to strategically address the health needs of street drinkers from new communities and to enable new communities with addiction and mental health issues to access treatment and support services. The project falls within a broader set of actions in the SICDATF 2018 and 2019 work plans that addressed the needs of new communities. The actions also include initiatives such as intercultural training for service providers, culturally sensitive translation of literature and websites, and access to translation services among others.

Community Response (CR), established in 1990, is a South Inner City Dublin based service. CR provides services to individuals and affected family members in the local community, addressing primarily alcohol use and liver health. The CKU Centre for Counselling and Therapy is also based in the South Inner City Dublin. It opened in 2009, and its establishment was in direct response to the needs of Polish people in Ireland and their families affected by addiction, offering services in the Polish language.

The SICDATF was established in 1997. It is a committee with representation from public representatives and the statutory, voluntary and community sectors. Among its roles are the responsibility for coordinating the implementation of the National Drugs Strategy in the context of the local area's needs and supporting and strengthening community-based responses to drug misuse.

1.2 A profile of the SICDATF area

The SICDATF geographic catchment area extends south along the River Liffey to the Grand Canal, bordered by the South Circular Road to the West and Poolbeg to the East, as detailed on the map (Figure 1).

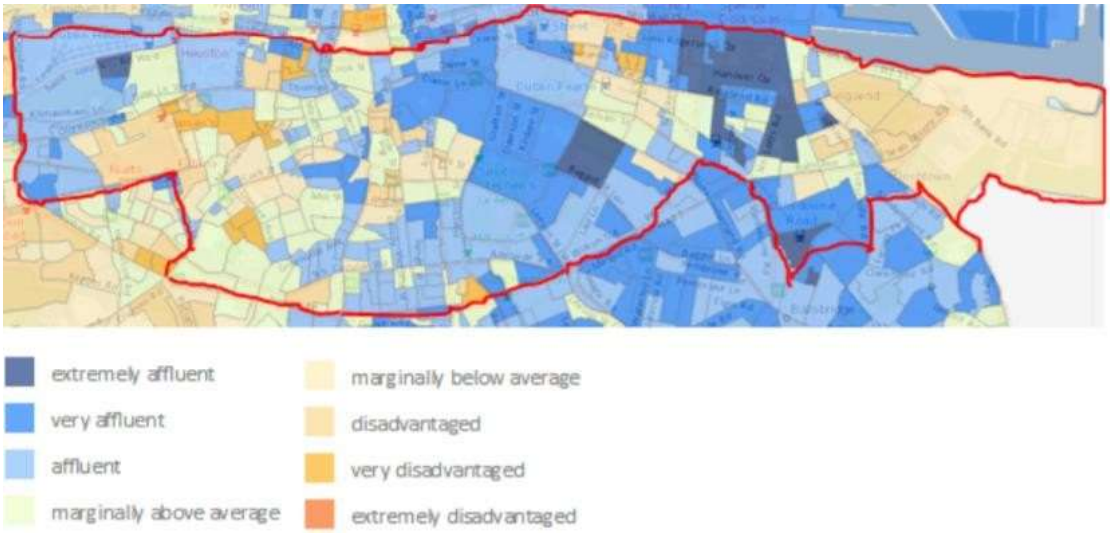

Fig. 1: Map of the SICDATF catchment area (Source: Quality Matters, 2017).

The socioeconomic profile of the area is diverse, ranging from very disadvantaged pockets to above-average affluent sections (Quality Matters 2017). The combined population of the constituencies Dublin South-Central and Dublin Bay South was 240,654 in 2016 (CSO 2016). The area is ethnically diverse and has a higher than national average population of members from new communities (Quality Matters 2017). The Mendicity Institution, a homeless charity based in the South Inner City, conducted a census amongst its service users in 2019, finding that 75% of its service users were EU migrants, primarily from Lithuania, Poland and Romania, and that 38% were sleeping rough (Mendicity 2019).

Data on treated drug and alcohol use for cases resident in the SICDATF area in the years 2016-2018 were extracted from the National Drug Treatment Reporting System (NDTRS) database with help from the HRB. These are reported in Table 1. The data are reported for all cases, and separately for non-Irish White cases. It shows that proportionally, more non-Irish White cases were treated for problem alcohol use compared to problem drug use.

Alcohol	**2016**	**2017**	**2018**
Total treated cases	137	166	206
Non-Irish White	13 (9.5%)	20 (12.0%)	20 (9.7%)
Drugs	**2016**	**2017**	**2018**
Total treated cases	277	257	369
Non-Irish White	7 (2.5%)	12 (4.7%)	24 (6.5%)

Table 1: Treated drug and alcohol use in the SICLDALTF area. (Source: HRB).

1.3 Evaluation aims & objectives

This evaluation aims to document the pilot project, present the key learningsfrom the pilot project, and provide recommendations that will inform the SICDATF on how to work effectively with new communities to address their needs and the issues they face.

More specifically, the objectives of the evaluation include:

- To carry out a literature review of relevant previous research in an Irish context.
- To produce a profile of the individuals who participated in the pilot project in terms of demographics, help-seeking behaviour in relation to Hep C, and patterns of substance use.
- To explore the views of the stakeholders of the pilot project.

1.4 Outline of report

Following a brief review of national policy relating to new communities and substance use, the report is broken down into the following sections:

- A description of the pilot project
- A literature review covering ‘new communities’ and substance use, and a brief overview of the Polish cultural context
- The methodology of the evaluation
- The aggregated findings of initial assessment forms used with participants
- The views of project stakeholders
- Conclusions
- Recommendations

2 Policy Context

New communities receive scant attention in the current Irish National Drugs Strategy, *Reducing Harm, Supporting Recovery* (DOH 2017). In the strategy, new communities are recognised as a group with complex needs that may experience barriers to accessing services, and it calls for a need to improve the capacity of service providers to accommodate the needs of this group. Under Objective 2.1, Action 2.1.27 seeks to

> Improve the capacity of services to accommodate the needs of people who use drugs and alcohol from specific communities including the Traveller community; the lesbian, gay, bisexual, transgender and intersex community; new communities; sex workers and homeless people. Fostering engagement with representatives of these communities, and/or services working with them, as appropriate;
>
> Considering the need for specialist referral pathways for specific groups who may not otherwise attend traditional addiction services;
>
> Providing anti-racism, cultural competency and equality training to service providers; and
>
> Ensuring all services engage in ethnic equality monitoring by reporting on the nationality, ethnicity and cultural background of service users for the NDTRS and treat related disclosures with sensitivity.

The HSE is the lead actor in this case, with the community & voluntary sectors and Task Forces as partners. There is limited information on the extent of progress on this action, except that the NDTRS is now capturing data on ethnicity, and that compliance with this is assessed when Service Level Agreements (SLA) are evaluated annually (DOH 2019).

The Second National Intercultural Health Strategy 2018-2023 (HSE 2018) includes one strategic action related to substance use, where it states to “Implement relevant recommendations in the new National Drugs Strategy” (p. 26).

3 Pilot Project Description

3.1 Overview

The pilot project had three complementary and interweaved strands. It was an action research project, an assertive outreach initiative, and a referral pathway model.

3.2 Action research

The pilot was an action research project. Those involved in the project defined the ‘problem’, developed the intervention as the possible solution to the ‘problem’, and

collected data as part of the intervention. As part of this process, ethical principles for the project were discussed and agreed upon. One of the components of the action research spiralis observation and reflection, and through this learning, an intervention can be modified (Cohen et al. 2007). Action research aims to improve practice and can be an important tool for change.

Data collection was done through an assessment form when the outreach worker met with the person on the street. The form was developed collaboratively by the steering group, drawing on the expertise of the group in areas such as cultural competency, the Polish language, Hepatitis C and alcohol interventions. The form servedtwo purposes, first as a tool for the assessment of the needs of this cohort, and second, as a support for the intervention by providing opportunities for harm reduction and signposting to services. The first section addressed consent, confidentiality, and data protection. The second section asked social demographic questions about gender, children, preferred language and living situation. The third section asked questions about Hepatitis C testing and treatment. The fourth section asked about the current use of substances, which included the AUDIT-C assessment. The form was available in Englishand Polish.

3.3 Assertive outreach work

The pilot commenced in November 2018 and concluded in December 2019. CKU was the first agency to begin assertive outreach, while CR started in March 2019. The bulk of the work took place in the second half of 2019, and at this time other addiction servicesin the area, Coolmine and Merchants Quay Ireland (MQI) became involved in the pilot.

Outreach work took place in teams of two, and where possible, the teams were a cross-agency. Initially, the teams went out in the morning time, around 11 a.m. However, the time was changed to the afternoon to access more people. Once an engagementhad taken place, and trust had been established, the assessment took place. A brief intervention model was used. The outreach workers engaged with the person, assessedtheir level of need, developed a care plan and/or offered the individual information on relevant supports and services. A typical intervention lasted 20-30 minutes. In the pilot, the outreach workers engaged with 45 individuals.

The geographical area covered by the project extended beyond the catchment area of the SICDATF as seen in Figure 2. While the South Inner City was the targeted area and where initial contacts took place, the nature of this cohort is the tendency to move across different locations in the city to access food, and shelter and to socialise with others. Accordingly, the outreach workers met with this cohort at identified hot spots. Each pin represents the street covered by the outreach services in the pilot project.

Fig. 2: Geographical area covered by the pilot project.

3.4 Referral pathways

The third strand of the project was a referral pathway for people who spoke Polish, and who were invited to attend treatment services at CKU.

3.5 Project budget

The final budget for the entire project was € 25,000. Approximately € 16,000 of this was allocated towards staff costs, with €3,200 going towards intercultural training and an evaluation of the project, and the remainder towards administrative and other related costs. The funding covered core staff costs, while the practitioners from Coolmine and MQI volunteered to become part of the project. There was no fixed budget to inform the

project

at the start, which meant that financial restrictions shaped the project and a flexible approach had to be adopted by the team as the project moved along.

4 Literature Review

4.1 Migrants in Ireland

After the accession of ten new countries to the EU in 2004, there has been a substantial increase in the number of immigrants who reside in Ireland. In April 2016, there were 535,475 non-Irish nationals living in Ireland, 11.6 % of the total population (CSO 2016). The largest non-Irish population group are Polish citizens, 122,515 people, followed by UK citizens and Lithuanian citizens. In Ireland, groups of people from immigrant minority ethnic groups are often referred to as 'new communities'.

4.2 Migrant health

Migrants have specific health needs, and this may present a challenge for drug and alcohol services. Fennelly and Flaherty (2017) especially highlight women migrants as a population with specific needs and concerns. Carta et al. (2005) report the key barriers to access services as views in new communities about drug use (e.g. shame and stigma); a lack of awareness about the services that are available and how to access them; perceptions about the services that are available; financial costs; physical access; language difficulties; and, service providers' attitudes and lack of cultural competency.

4.3 Migrant substance use

There is limited published Irish research on migrant health generally and a dearth of literature on migrants and substance use. A 2019 scoping review of peer-reviewed Irish research on migrant health identified a total of 80 articles (Villaroel et al. 2019), of which only one addressed substance use (alcohol use in pregnancy). In the grey literature, specific to new communities and substance use, only four Irish reports have been published:

- 2004 Merchants Quay Ireland: *Drug use among new communities in Ireland: an exploratory study* (Corr 2004). This was an exploratory, qualitative study on problematic drug use in new communities, and included participant observation, interviews with People Who Use Drugs (PWUD) and service providers. Barriers to accessing services were noted to be a lack of knowledge of services, language difficulties, stigma and shame,

fear of encountering racism. Outreach work, having services with staff from new communities and drug awareness training with new communities, using information about services that indicate that they are accessible and welcome diversity were recommended as approaches for engagement with this group of PWUD.

- 2009 Western Region Drugs Task Force*: Substance Use in New Communities: A Way Forward* (Kelly et al. 2009). This report created a profile of new communities in the West of Ireland. Having consulted with organisations working with new communities on their perceptions of substance use and new communities, the authors concluded that there was a relatively low level of concern about substance use in new communities in the region. The report's recommendations for service providers, therefore, focused on coordinated preventative and proactive actions.

- 2016 Canal Communities Local Drug & Alcohol Task Force: *The use of drugs and alcohol by new communities in the Canal Communities Local Drugs and Alcohol Task Force area* (Archways 2016). This commissioned qualitative research explored access to drug and alcohol services by new communities. Using interviews with local projects, it found that no persons from new communities presented to frontline services at the time of the research, and in the past, the numbers that had presented were small. On the other side, there was a perception that there were issues of problematic substance use in this population, but that they were not accessing treatment.

- 2017 CityWide: *Stimulating and Supporting a Black and Minority Ethnic Voice on Drugs Issues* (Crowley, 2017). This paper was commissioned by CityWide to explore possible structures and processes through which to engage with and empower new communities in relation to drug use issues. Interviewees from ethnic minority organisations reported that drug and alcohol issues had not emerged in the course of their work, but that it was a hidden issue. Similarly, interviewees from drug and alcohol service providers noted that problematic drug use was an issue, but that there was no quantitative data on the extent of the issue. The report noted low take-up of services, with specific barriers described as lack of knowledge about services, isolation, lack of family support networks, legal status, community issues such as shame and stigma, language

barriers, absence of targeted and/or outreach services, lack of cultural competency of services and racism.

There is a lack of published national data on prevalence of substance use or treated problem substance use specific to new communities. The most recent Health Research Board (HRB) reports on trends in the treatment of problem drug and alcohol use refers to Irish Travellers, but not to any other minority ethnic groups (HRB 2019 a, b). The potential information that could be generated from this system is limited by the fact that people from new communities are not accessing services in large numbers (Crowley 2017).

4.4 Service provision

Apart from CKU, a desktop search of addiction services in Ireland that work specifically with new communities has yielded no results. Some services have outreach projects that target new communities, for example, Coolmine has an outreach worker for Travellers and New Communities based in North Dublin. There are AA groups that hold meetings in different languages, such as Polish.

5 Cultural context: Poland

5.1 Introduction

The demographic profile of the cohort that was accessed in this pilot study indicates that a large majority of the participants were from Poland and that the preferred drug of choice was alcohol. It is, therefore, useful to briefly review the literature in terms of the cultural context and responses to problematic alcohol use amongst Polish immigrants.

5.2 Alcohol consumption in Poland

The WHO reported on alcohol use in Poland in 2018, comparing it to the rest of the WHO European region:

Alcoholic drink of choice

In 2016, beer had the highest recorded per capita consumption (56%), followed by spirits (36%) and wine (8%).

Alcohol per capita (aged 15+, litres of pure alcohol) 2016 data

11.6 in total population; males 19.2/females 4.7 (9.8 in WHO European region)

17.1 among people who are drinkers in 2016 (23.8 males/8.3 females)

Prevalence of heavy episodic drinking in 2016 (>60 g one occasion past 30 days)

35.1% total population (54.5% males & 17.5% females)

51.6% of drinkers (67.3% males & 31.1% women)

Prevalence of alcohol use disorders and dependence in 2016

Alcohol use disorders: 12.8% of population (22.7% males & 3.7% females)

WHO European region is 8.8%

Alcohol dependence: 2.2% of population (4.1% males % 0.4% females)

WHO European region: 3.7%

Notably, while the rest of Europe has noted a reduction in alcohol consumption between 2001 and 2012, rates increased by 30% in Poland (Gupta 2016). Alcohol is accessible, and relatively cheap in Poland, compared to the rest of Europe.

5.3 Cultural and systematic differences

Gilchist et al (2013) reviewed access to drug and alcohol treatment in Europe and noted that In terms of access, health care, including treatment for drug and alcohol problems, in Poland is free of charge and does not require a referral from a GP. The most common treatment for alcohol dependence in Poland is integrative psychotherapy using a psycho-social model, and barriers to accessing treatment are mainly cultural, for example, shame and fear of stigmatization (Szczegielniak et al (2014). Abstinence-based models of treatment dominate.

5.4 Polish migrants and alcohol use

For the purpose of this report, the author could not access any published research that has been conducted with Polish immigrants in Ireland in relation to problematic alcohol use. Hence, our understanding of patterns of alcohol consumption, help-seeking behaviour and experiences of services in this population is extremely limited. The findings that emerge in this pilot study will start to fill this gap in the literature.

However, looking at our closest neighbour, a small body of research exists. Like in Ireland, Poland is the most common non-UK country of birth in the UK. The limited research with, and targeted service provision for, the Polish immigrant community is also a concern in

the UK. Data from the UK indicates that is a vulnerable population, with high levels of suicide, depression and poverty (Lakasing and Mirza, 2009).

A published case study of the Barka pilot project in London (Hammersmith and Fulham) reported on a six-month pilot which sought to address the needs of migrant street populations from Poland, most of whom were street drinkers (Lakasing and Mirza 2009). The local authority partnered with a Polish charity (Barka) and the Broadway Day homeless service. The project targeted the Polish street population, with a view of relocating individuals back to Poland where they could access treatment services or reconnect with their families. There is no published information on the outcomes of the project.

A report on the mental health and well-being of Polish migrants in Northern Ireland found that migrants often experience chronic stress, manifested through insomnia, anxiety, depression, drug and alcohol dependence and suicide (Kouvonen et al. 2014). The report notes that Polish migrants lack social networks for everyday emotional support, leadingto feelings of social isolation. Low levels of proficiency in English are a barrier to help-seeking, and many participants in the study felt that the use of a third-person interpreter acted as a barrier to speaking about sensitive issues.

Alcohol Change UK commissioned a report that explored alcohol treatment pathways among Polish immigrants in North London (Herring et al. 2019). This qualitative study with service users and service providers found that while men were drinking in social gatherings, women tended to drink alone due to stigma and gender-based societal and polish cultural norms of being a woman and a mother. It found that most participants sought help only when drinking caused significant health or social problems. It was theorised that this help-seeking behaviour is linked to a Polish culture where drinking is normalised and a belief that people should be able to have control over their drinking. Harms associated with drinking included mental health problems and homelessness, and, additionally, domestic violence and financial difficulties for women. In terms of treatment, abstinence rather than reduction was the goal for most participants, reflecting the medical model’s dominant orientation of addiction treatment in Poland. On the other hand, another cultural influence, a strong work ethic, was a strong enabler for successful treatment and

recovery. The Polish addiction service was highly valued by participants because of language, but also the cultural understanding of values, needs and approaches to support. However, the study noted a gap in aftercare services apart from AA meetings held in the Polish language. Finally, many service providers felt that addressing issues outside addiction, such as homelessness, employment, education and domestic violence was important for successful outcomes.

6 Evaluation methodology

This evaluation comprised three distinct activities: desktop research, analysis of assessment forms, and project stakeholder interviews.

Desktop research was undertaken to identify previous research on new communities and substance use in Ireland and elsewhere to review the literature on migrant health and substance use, identify projects that specifically target new communities in Ireland and the UK, and understand and summarise the Polish cultural context.

Project stakeholder interviews were conducted with eight individuals in February 2020:

- Manager, CKU
- Manager, CR
- Coordinator, SICDATF
- Counsellor, CKU
- Project worker, CR
- Project worker, Coolmine
- Project workers (2), Merchants Quay Ireland

The interviews were recorded with verbal consent and lasted approximately 20 minutes. A topic guide was used to steer the interview and to ensure consistency from one interview to the next. The areas covered in the interviews included a description of interventions (when the interviewee had directly engaged with people drinking on the street); perceived barriers for this cohort accessing services; the perceived needs of this cohort; views of the pilot project in terms of challenges and success factors, and,

recommendations for future activities. Analysis of the interview data was done thematically under these pre-set themes.

7 Profile of pilot participants

7.1 Overview

A total of 45 people participated in the pilot project, however, not all participants responded to all questions. This section will outline the demographic profile of the people who took part in the survey; the findings relating to Hep C testing and treatment; and, the findings relating to patterns of substance use.

7.2 Demographic profile

- Gender: Of the 44 people who responded to the question of gender, 10 (22.7%) were female, and 34 (77.3%) were male.
- Children: Of the 34 people who responded to the question “Do you have children?”, 19 responded yes (55.9%). Most (eight) people stated that they had 1 child, followed by two children (six), three children (two) and four children (two). Most (18 of 21 who responded) did not live with their children.
- Language of choice: Polish was by far the most common language of choice as indicated by 30 people (68.2%). English was the next language as indicated by eight people (18.2%). Other languages, chosen by one person, included Hungarian, Czech, Russian, Lithuanian, Slovenian and Somalian.
- Current living situation:
    - Homeless, sleeping rough: 13 (29.5%)
    - Homeless hostel: 11 (25%)
    - Friends or family: (18.2%)
    - Lives alone: 4 (9.1%)
    - Stable: 2 (4.5%)
    - Private rented: 1 (2.3%)
    - Detox unit for homeless: 1 (2.3%)
    - Dublin Simon 1 (2.3%)

7.3 Hep C Testing & treatment

- Hep C testing: Of the 44 people who responded to this question, 26 (59.1 %) indicated that they had never been tested for Hep C. while ten (22.7%) stated yes. Eight people were not sure if they had been tested.
- Hep C test result: 15 (34.1%) people reported their test as negative and one person reported it as being positive. Ten (22.7%) stated that they were not sure of the result.
- Hep C treatment: 25 (56.8%) stated that they had never been treated for Hep C, one person stated that they had been treated for Hep C, while five (11.4%) were not sure.

7.4 Pattern of substance use

- Drug of choice: Alcohol was by far the most preferred drug of choice by 34 people (77.3%). The second most preferred drug was cannabis by 9 people (20.5%). Other drugs included heroin, amphetamines and crack cocaine, each preferred by one person.
- Preferred form of alcohol: Beer by 14 (38.9%), wine by 12 (33.3%), spirits by eight, (22.2%) and cider by three people (8.3%).
- Frequency of drinking:
    - 4+ times per week: 29 (78.4%)
    - 2-3 times per week: 6 (16.2%)
    - 2-4 times per month: 2 (5.4%)
- Typical standard drinks of alcohol when drinking:
    - 10+ standard drinks: 26 (72.2%)
    - 7-9 standard drinks: 6 (16.7%)
    - 5-6 standard drinks: 1 (2.8%)
    - 3-4 standard drinks: 2 (5.6%)
    - 1-2 standard drinks: 1 (2.8%)
- Frequency of drinking 6+ standard drinks if female, or 8+ if male, on a single occasion in the last year?
    - Daily/almost daily: 28 (73.7%)
    - Weekly: 9 (23.7%)
    - Monthly: 0

- Less than monthly: 1 (2.6%)
- Never: 0

7.5 Summary

To conclude, a snapshot picture of the cohort that the pilot engaged with shows that three-quarters were male. Over half in this group had children, but most did not live with their children. Three in ten were sleeping rough, while another third lived in hostels or with family/friends. Almost 70% spoke Polish as their preferred language.

Three-quarters of this group had never been tested for Hep C or did not know if they had been tested. Only one person knew that they had tested positive for Hep C and had undergone treatment. However, the responses to the Hep C questions are inconsistent, possibly indicating a lack of awareness of the infection in this group.

Alcohol (beer and wine) was the drink of choice for three-quarters of this group, followed by cannabis. The aggregate scores on the AUDIT-C assessment are high, indicating that this group are at high risk of alcohol-related harm.

8 Views of project stakeholders

8.1 Introduction

Interviews with eight individuals yielded qualitative data about the pilot project. The recorded interviews were analysed thematically, and the findings are presented under these themes: barriers to accessing services; what worked well in the project; what were the challenges in this project; recommendations for future similar work.

8.2 Barriers and presenting issues

8.2.1 Communication

All interviewees mentioned language difficulties as a barrier. It was noted that some Polish migrants may have lived in Ireland for 10-15 years but have very limited English language skills, as they tend to live and socialize with their peers. While some are aware of English courses, engaging with education while living in an unstable and unsafeenvironment is challenging or impossible.

The interviewees suggested that to overcome the language barrier, there is a need for literature, forms and information in different languages. There is a need for services with

staff that speak different languages. There is a need for support to complete applications and forms that are in English and online, e.g.in relation to Social Welfare or access to homeless services. Some individuals may not have access to the internet or a smartphone to access online services and this barrier needs to be addressed.

8.2.2 Lack of awareness of services

Lack of awareness of existing services was noted as another barrier. Most of the participants in this study use alcohol as their main drug of choice. While some individuals are aware of the larger services in the area, there was a perception among street drinkers that alcohol users and drug users are different, and that they did not wish to access services that also offered needle exchange services, as they felt that they do not belong there. They might not be aware of the smaller niche services such as CKU or CR.

8.2.3 Lack of services

As is the case with a large number of people who engage in problematic substance use, thiscohort of individuals often have concurring mental health problems, and there is a need for an accessible and culturally competent dual diagnosis service.

8.2.4 Cultural barriers

There may be a lack of understanding of how the Irish system works. One example provided was a lack of knowledge about the criteria and waiting time to access a detox facility, which may be different from the practices in the countries of origin.

Some street drinkers, especially men, do not believe that their drinking is a problem and that they do not need an intervention. They do not want to change their behaviour and are not ready for an intervention.

In new communities, such as the Polish community, there is a perceived stigma attached to attending a treatment service, which also acts as a barrier. There is a shame attached to family knowing that an individual is undergoing treatment. There is also shame and stigma associated with being tested for Hep C, as this is seen as an infection that drug users acquire.

Women’s needs are seen to be more complex, compounded by issues such as having children in care, lack of knowledge of how TUSLA works, domestic violence, and having

no family network for support. There is a stigma attached if a child had been taken into care, as cultural norms around motherhood are broken.

To overcome the cultural barriers, there is a need for specific targeted services such as CKU, but also mainstream services to understand cultural diversity and how to targetand work with people from different cultural backgrounds.

8.2.5 Structural barriers

This cohort of street drinkers is a very vulnerable and socially excluded group due to long-term unemployment compounded by long-term homelessness in many cases. The lack of stable and safe accommodation for this cohort was frequently referred to as a barrier to engaging with addiction treatment. Basic human needs, such as housing and physical health, need to be addressed before an individual can start addressing their addiction in a meaningful manner. It was felt that it was difficult to even try harm reduction approaches, e.g. reduction in use, as long as the individual remained homeless.

It can also be difficult to access service if an individual is not captured within 'the system'; for example if they do not have a PPS number, if they are not in receipt of socialwelfare, or if they are not registered as a homeless person (in the case of detox).

8.3 The model of intervention: outreach

In the main, project participants felt that the outreach model of intervention was an effective way of engaging with street drinkers. In the main, the individuals they met were willing and open to engaging with the outreach workers, but there were also cases where individuals were suspicious or just did not want to engage. Using existing relationships between outreach workers and individuals was seen as helpful for engagement to take place.

Outreach working requires a strong skill set. Building trust on the street is challenging, and gaining trust is the first step to an effective engagement. The initial approach by the outreach worker is key. He or she needs to be warm, friendly, caring, approachable and non-intrusive in their approach.

The target group can be difficult to find. They can congregate at a certain location at a certain time but can be gone the next hour. They can move around to different places in

the city during the day. Hence, the timing of outreach work is important, and local knowledge and experience are key to reaching people.

There is a transient nature to the population of street drinkers, depending on where they locate sheltered accommodation. Therefore, it can be difficult to sustain consistent engagement with individuals.

Factors such as weather impact outreach work. During periods of bad weather, street drinkers might be sheltering and therefore not easy to find. It is also difficult conditions to work for the outreach workers.

Working in pairs is necessary during outreach work. This is for safety reasons, but it also strengthens the intervention. In this case, the interagency pairing up of outreach was useful as it pooled skills, local knowledge and outreach experience. In the case of an outreach worker from CKU pairing up with another worker, it had the additional benefit of having a Polish speaker on the team, which made engagement with the Polish community easier. The drawback to outreach work is that is intensive in terms of resources and time

In terms of outcomes of the street intervention, there were accounts of individuals who had engaged with services after the engagement with MQI (and progressed to Simon Detox), CR and CKU for further support.

8.4 What worked well

The interviewees were asked about what they felt had worked well in the pilot and all agreed that the interagency collaborative approach had been very effective, with several mutual benefits. Benefits included: pooling of resources, experience, skill sets, local knowledge; increased referral across services; gaining in-depth knowledge about thework of agencies; and, exchange of information. The fact that the interagency collaboration was cross-cultural added significantly to shared learnings and benefits.

It was noted that there was a high level of commitment and interest in the project from all the agencies and individuals involved in the pilot. Despite the financial uncertainty, a high level of enthusiasm and flexibility had been demonstrated by those involved in the project.

In terms of the intervention, the most effective engagements involved those that used existing relationships between outreach workers and individuals not only to engage with that individual but also for that individual to encourage other peers to engage.

Stakeholders noted that participating in the pilot project provided an opportunity to reflect on how the service could change to be more accessible to this cohort.

Finally, the existence of a service that is delivering interventions in the Polish language, and is using approaches similar to those provided in Poland resulted in a lessening of language and cultural barriers to accessing services.

8.5 Challenges

A challenge of the interagency collaboration was the practicalities of coordination of staff for outreach work from the different agencies. As the outreach work was done on top of the normal workload for the volunteers from Coolmine and MQI, it was sometimes difficult to schedule. In addition, if there was a crisis, this work had to be prioritised andoutreach sessions had to be cancelled on occasion. In addition, the number of outreach workers in each agency is relatively low.

Not knowing the exact budget at the start of a new initiative was a challenge. The budget for the project was uncertain and relatively small and had to be micromanaged for the most effective use of resources. This was overcome by using a reflective and responsive approach to the work, focusing on the presenting needs.

The pilot project was of relatively short duration, and it was noted that an initiative suchas this needs space and time to grow and embed.

There was no existing model of intervention to use as a template for the pilot. The approach to intervening street drinkers from new communities, most of whom with no stable accommodation, is different from the approach taken with other ethnic minority groups, such as Irish Travellers or Roma.

The lack of stable and safe accommodation for many individuals in this cohort is a challenge for outreach engagement, as the basic human needs should be addressed before the problem of alcohol use can be approached.

9 Conclusions

This report has reported on the evaluation of a pilot project with three strands: an action research project with data collection, an assertive outreach service with street drinkers from new communities in Dublin, and a referral pathway for street drinkers whose preferred language was Polish. The evaluation included a review of literature, a review of assessments conducted with 45 participants, and interviews with eight project stakeholders from the five agencies involved in the pilot.

The literature on new communities and substance use in Ireland is very limited, and non-existent referring to street drinking and new communities. There are also no examples of models of best practice for engaging with this specific cohort. The existing literature indicates that substance use is an issue in new communities in Ireland, and the level of engagement with services is low. This has been recognised in the National Drugs Strategy, which states a need to improve the capacity of service providers to accommodate the needs of this group.

This evaluation found that barriers to accessing services included: stigma and shame, communication barriers, cultural and systematic barriers, lack of awareness of services and lack of stable accommodation. These concur with previous national and international research.

The profile of the individuals that were engaged in this pilot indicates that this cohort is mostly male, most have Polish as their language of choice, most have no stable accommodation, and most use alcohol as their drug of choice. Project workers felt that most individuals were happy to engage with the outreach workers, while in some cases, there was some suspicion. Building trust on the street is challenging, but the thrust is centralto a positive engagement.

All stakeholders interviewed for this evaluation felt that the model of intervention employed in the pilot was suitable, effective and accepted by the target group. The key strength of the project was the interagency approach that was employed and the interest and commitment displayed by all stakeholders.

Finally, there was a strong recognition among the stakeholders that street drinkers from hew communities are a marginalised group, part of the local community, and that their needs need to be addressed as a human right.

10 Recommendations

“We need to adapt what we are doing to meet their needs and welcome them and accept them for who they are” (Interview participant).

Several recommendations arise from this evaluation relating to both the model of intervention specifically and the reorientation of services generally, to better meet the needs of members of new communities.

10.1 The model of intervention

Skilled outreach work, using a brief intervention model, is an effective way of reaching this cohort and is recommended going forward.

All services that incorporate outreach work should aim to target street drinkers from new communities as part of the outreach worker’s brief.

The interagency approach adopted in this project pools resources, skills and local knowledge and should continue to be used.

In the future, short and longer-term outcomes for the clients should be tracked if possible.

In terms of the population that was targeted in this pilot, it is clear that broader issues such as physical health and homelessness need to be addressed as a priority tosupport the individuals around their use of alcohol. Addressing issues such as addiction and language proficiency can only start if the person is in a safe and stable environment.Only then can this vulnerable population start their social integration.

10.2 Reorientation of services

To address the language barrier, printed and online materials and forms should be published in languages other than English. They should also be ‘culturally translated’so that they are meaningful for people from new communities. Information about the service should be provided in several languages.

In services that do not have staff members that speak other languages, sometimes interpreters or friends as interpreters are used. This is helpful, but can also act as a barrier to the therapeutic relationship. It is ideal to have staff members that can communicate in different languages.

Services need to ensure that they come across as accessible and welcoming to people from, new communities. These can be simple symbolic ideas, such as a ‘hello’ sign in different languages, or information on the door such as opening hours in other languages. English speaking staff members can endeavour to learn a few phrases in other languages.

Gender-specific approaches should be considered when working with street drinkers as presenting issues are different by gender.

The interagency approach adopted in this project is an example of good practice and should continue.

Stakeholders in this project suggested that funding should be provided for a new communities project worker that could support the work of all relevant agencies in the local community, and this should be considered.

Services should ensure that all staff members undergo intercultural diversity awareness training, which will build organisational knowledge and capacity.

Services can do a self-assessment of their current level of cultural responsiveness, and reflect on changes that are feasible and implementable in the short and long term.

Services should include the voice of new communities when planning and implementing interventions.

Services can engage with hostels and community-based migrant services to raise awareness about the available services.

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