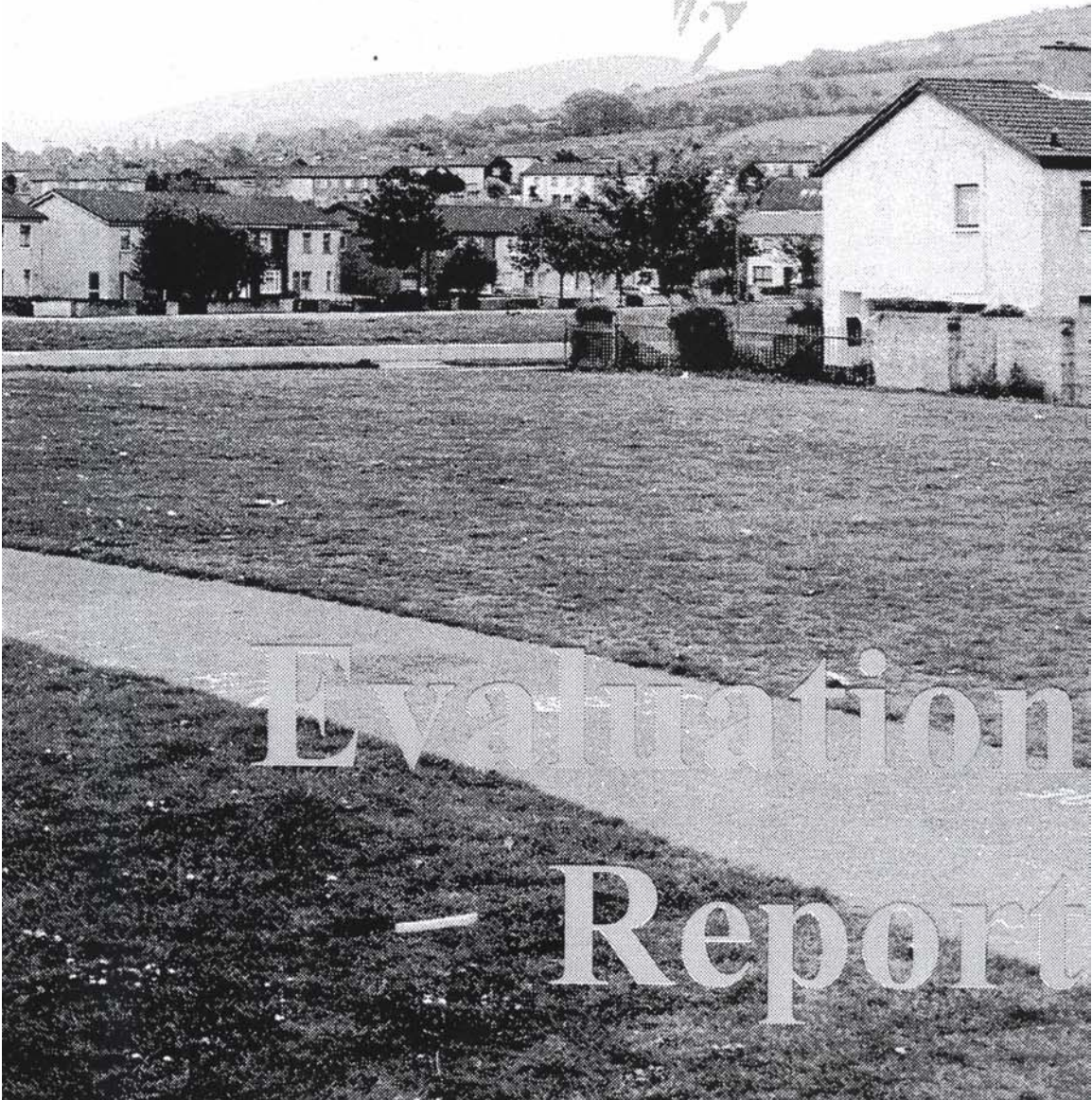


CARP

Killinarden



Evaluation
— Report

**COMMUNITY ADDICTION RESPONSE
PROGRAMME CARP – KILLINARDEN**

REVIEW AND INTERIM EVALUATION REPORT

FINAL REVISED DRAFT

**MATT BOWDEN
DECEMBER 1997**

FOREWORD

We welcome the publication of this evaluation on CARP-Killinarden. It comes at a time of both developmental and structural changes in CARP. At a time when there is a visible physical structure - our new portacabins. Since we first began in 1994 as a small group of parents of drug misusers we have always tried to have a holistic response to drug addiction. We see it not only as a medical problem but also one that has serious consequences for the individual misusing, the whole family and their community. We believe that since most of our drug users learned their drug misusing in our community over a long number of years then their dealing with it must also be within this community and over a period of time.

When we started we had to struggle very often in the dark. We would like to record our thanks to those individuals and other drug responses in the greater Dublin area that helped give us light. By far the greatest inspiration was a meeting with a Dr John A Marks of Widnes, Cheshire who treated us with courtesy and openness. We did research amongst drug misusers in Killinarden and we thank them for their trust in us. We owe our greatest thanks to the Killinarden Community Council who supported us from the very beginning. They provided us with meeting rooms, phone and fax facilities etc. when we were poor (we still are) and whose continued backing is still appreciated. We wish to acknowledge the support of the wider Killinarden community who allowed us to proceed with setting up the programme. This was in stark contrast to similar communities all over Dublin. The other great input into our development was our meeting with Dr Anjum Madani who agreed to be the doctor to do the prescribing. All these inputs came to fruition at the setting up of the programme in July 1995.

Since then the programme has developed and expanded. Many different people had an input into this. As the programme was developing an inordinate amount of time for the first two years was spent in procuring financial backing for the programme. Eventually a £25,000 grant from EHB was received in October 1996. This continues to be an area of difficulty for us.

Since we were a unique response to drug use and since most of us did not have a background in addiction it was felt that that there was a need to convince others that we were actually doing a good job. With this in mind we undertook training in addiction and were responsible for bringing Addiction Studies to the RTC Tallaght. In our discussions with statutory bodies, both national and international, it became clear that our own internal evaluation need some objectivity. With that in mind we applied to Combat Poverty Agency for a grant. Tallaght Partnership facilitated us with the application and we were successful in drawing down this grant in early 97. With this grant we were able to pay the bulk of the cost of the evaluation. To both Combat Poverty Agency and Tallaght Partnership we express our gratitude.

We would like to thank Matt Bowden, our evaluator, for the work that he did with us -often beyond the call of duty. We hope that this evaluation will help other groups and communities as they struggle to respond to drug addiction within their own communities.

CARP – KILLINARDEN
Review and Interim Evaluation Report
Matt Bowden
December 1997

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INTRODUCTION

1.1 Scope of the Report

This report is a retrospective review of the Community Addiction Response Programme (CARP) – Killinarden. Also, the report constitutes an interim evaluation of progress of the initiative, two years after it came into existence. The report reflects upon the historical antecedents and the development of CARP as a particular response to the issue of problem drug use in Killinarden, Tallaght, on the outskirts of Dublin City. In addition, the report critically assesses the effectiveness and impact of CARP based upon its own underlying assumptions and aims. The report identifies key issues for further development. There are critical developmental issues faced by CARP which cannot be divorced from the impact of the programme. As the organisation develops, the effectiveness of the initiative on the ground will also develop. At this point, CARP is a young organisation and is realising only a fraction of its overall potential. As such, this review and evaluation can only be relevant as an interim report on its progress to date.

1.2 Terms of Reference

The Combat Poverty Agency provided a research grant to CARP to undertake this evaluation and review. CARP commissioned an independent researcher, Matt Bowden, to:

- (i) Establish the appropriateness of the approach adopted;
- (ii) Establish performance indicators and benchmarks against which to measure success;
- (iii) Establish the strengths and weaknesses of the programme so that other communities may benefit from the experience of the CARP project¹.

The evaluator reinterpreted element (ii) of the terms of reference to read as follows: to clarify the programme assumptions, goals and objectives. This was necessary as during the review process it became evident that this process had never been undertaken within CARP. Such clarification was required before

¹ As such, this is not an evaluation of methadone maintenance per se.

CARP could then set about establishing performance indicators. It was the view of the evaluator that not much consideration had been given to more fundamental issues necessary for the development and maintenance of CARP itself.

CARP'S own goal in undertaking an evaluation at this stage in their development is to develop a strategic plan for the 1997 to 1999 period. For CARP, a key question underlying the need to evaluate has been how to define the service to be delivered and how that service is organised. Moreover, how would the service incorporate the local community, the statutory service providers and medical professionals? For CARP to develop it requires an appropriate framework and a structure. Thus, at this point in its life cycle it is seeking to address the need for developing community structures in partnership with statutory and private sectors to aid the rehabilitation process.

1.3 Methodology

This review and interim evaluation has utilised data and information drawn from:

- a review of appropriate internal documentation including, minutes, correspondence, reports and proposals;
- a series of semi-structured interviews with staff, team members², professional personnel attached to the programme, statutory agency personnel, the Tallaght Partnership, members of community organisations and programme participants;
- a review of appropriate academic and policy literature.

Interviews with non-participant informants were conducted for the purpose of identifying key developmental issues and to clarify the underlying assumptions and objectives of the programme. In addition, these interviews were used for informing the broader impact of CARP in terms of how it linked with agencies and how, if any, it had wider effects at community level.

² The CARP team is the de facto management committee but has not referred to itself as such so as not to confuse it with other committees in the Killinarden area.

Interviews with participants were conducted in order to gain an insight as to how the programme effected individual change (see section 3) and to verify the impact of CARP'S programme. Also, these interviews identify new issues themselves which may provide the raw material to aid the reflection of those involved in managing and directing CARP. Those interviewed were those who volunteered from participants attending the centre on a typical day. Interviewees were approached by the CARP co-ordinator at the request of the researcher. Those agreeing to meet the evaluator were briefed on the purpose of the interview and asked if they would consent to an interview.

Interviews (15 in total) were conducted with

- community development co-ordinator for Tallaght Partnership who acted as key person in the process to establish the Local Drugs Task Force;
- community development officers with South Dublin County Council;
- senior counsellor with the Eastern Health Board addiction service;
- chairperson of Killinarden Community Council and member of the Local Drugs Task Force;
- members of the CARP team;
- CARP co-ordinator;
- medical doctor associated with CARP;
- part-time counsellor associated with CARP;
- project worker and project secretary;
- five participants on the CARP programme.

The Eastern Health Board area manager for addiction services was contacted but was unavailable for interview.

2. HISTORY AND DEVELOPMENT OF CARP - KILLINARDEN

2.1 Drug Use in Killinarden

Residents and community activists became aware of a synthetic opiate use problem in mid-1994 and subsequently of an escalation of problematic heroin use towards the end of that year. Prior to this, those taking heroin were an easily recognisable group of young people who were also engaged in criminal activity. When the heroin problem escalated it was clear to those involved that the profile of those using the drug had dramatically changed:

“Before, it was a few. Everybody knew them and they were involved in robbing and all sorts of things. They were well known. Involved in crime some of them. But when local people began to notice that some [were those who] had their leaving certs, and using heroin. Then it was different” (interview with CARP co-ordinator).

2.2 Initial Response

Despite the emergence of a serious opiate use problem in the area in this period, the availability of services was confined to those located in the City Centre. This provided little incentive for users to attend, given its physical distance. The Killinarden Community Council (KCC) was concerned at this point to ensure that any developments would deal only with those drug users who were from the Killinarden area. Initial approaches to the Eastern Health Board began in late 1994 when the KCC contacted the Director of Community Care. An initial meeting was set up at which the issues were presented. Essentially, from its very beginnings, CARP was a sub-committee of the KPCC. Much of the initial impetus to establish a response to the treatment issue was developed within a west Tallaght context. At this point also, a lobbying campaign began under the auspices of the West Tallaght Combined Residents Association (WTCRA) with the clear intention to establish a clinic in the area. Interestingly, it is somewhat unusual in historic terms at this point, for a community to be asking for the establishment of such a clinic, given that much preoccupation of tenants and residents groups in Dublin at the time, was in mobilising against the siting of clinics in their areas.

Prior to recognising the escalation of drug use in Killinarden there was a problem with the reckless driving of stolen cars by a group of young people. A group came together with Liam O'Brien³, comprised largely of the mothers of young people who were involved in stealing and driving stolen cars. A stock car circuit was organised where young people could drive around a field site in relative safety. A similar approach was adopted when the drug issue began to emerge in that a group was set up to explore the issue and develop a response.

While it was evident to the families of drug users and to some key activists in the area that there was heroin use going on, treatment facilities were not immediately available in the Tallaght area. Indeed, the only available option was Trinity Court in the City Centre which involves an 20 mile round trip by bus.

A group of mothers of drug users came together with Liam O'Brien and began meeting in the autumn of 1994. The initial focus of the group was in raising their own awareness of drug use by understanding the signs and effects. They began discussing the problem in broader terms also and decided that they would undertake initial research as a way of developing an appropriate treatment service for the area. Field trips were undertaken to the Merchant's Quay Project, Trinity Court, Aishling Clinic and the Youth Action Project in Ballymun. A visit was made to a treatment initiative in Liverpool. This latter trip had a crucial impact both on the type of service that CARP would later develop and on the underlying assumptions which it would adopt in planning its programme. The Liverpool initiative, a treatment clinic which prescribed heroin to heroin users, reported to the visitors that the impact of such prescription was to significantly reduce crime in the area insofar as heroin users did not have to steal money to buy drugs. The Liverpool initiative also reported that they were effective in reducing the risk of spreading HIV.

³ Liam O'Brien was working as a school chaplain in Killinarden Community School at the time.

Some of the mothers in the group had sons attending Dr Anjum Madani at Leonard's Corner at the time and introductions were made. Dr Madani operated according to a strict geographical catchment and would not accept clients from Tallaght. Those who had attended did so by giving addresses of grandparents or siblings living in the Dublin 8 or 12 areas. The mothers had witnessed at first hand, the impact of methadone maintenance on their families. It gave them 'peace' and made living 'bearable'. A delegation from the West Tallaght Combined Residents Group met with Dr Madani and with an American entrepreneur who was assessing the feasibility of establishing a commercial treatment facility in the Tallaght area.

This group was initially intent on bringing about a service which would provide for the Tallaght area as a whole. The initial goal of the West Tallaght group was to establish a community based prescribing practice while a clinic was being set up. It was considered at the time that this initiative would create the conditions for establishing a clinic in that it would allow communities to get used to the idea of the prescription of methadone in advance of a clinic facility.

At this point, there was a degree of disbelief in official circles, that there was a heroin use problem in west Tallaght. Epidemiological data which informs official policy-making in relation to drug use in the State, did not indicate that Tallaght had a serious problem at that time. Data is gathered at treatment facilities and as such is not sufficient for mapping out emerging problems. As the only treatment facility available to Tallaght residents was in Dublin city centre, they may not have opted for treatment in sufficient numbers to significantly effect the data.

In linking with the Eastern Health Board, those involved in the West Tallaght group became aware of the slow speed of movement towards a treatment facility and deepened moves to establish their own. It began to emerge also that the prevailing mood in the Killinarden area was for a small scale treatment facility

which would only deal with those living on estates within the Killinarden parish. Discussions with Dr Madani had also developed to the extent that there was an emerging realisation that two sites in west Tallaght would have to be used if the initiative was to win the support and legitimacy of the community in the respective parts of the area.

The annual general meeting of the Killinarden Community Council presented an ideal opportunity for the KCC drug sub-group to consult in relation to the setting up of a prescribing practice. At the meeting there was a degree of fear about the establishment of the programme. Those present were resolved that the initiative should be confined to Killinarden as a way of controlling the inflow of drug users to the area. In order to establish the feasibility of the programme the public meeting gave their assent to a programme being established which would only cater for twenty participants.

Some of those present, including members of the sub-group, thought that there was an assumption amongst those present that the programme would be short-term in that participants would be prescribed methadone for a period and gradually withdraw. This may have been the result of those present not fully being aware of the technical distinctions between detoxification and methadone maintenance. The programme began in July 1995 when it accepted its first participants. Only one pharmacist in Tallaght agreed to prescribe methadone which would have to be paid for by participants. They would also have to pay for the doctor, as his services were not available on the General Medical Scheme (GMS). The Fettercairn Drug Programme established its service at the same time as CARP.

2.3 Developing an Organised Treatment Response

Community based initiatives in relation to drug use in Ireland have largely steered clear of the provision of direct medical treatment and especially so the

provision of methadone. CARP is unique in that it has overcome many of the social and moral taboos which prevail in relation to the provision of clinics.

In its essence, CARP is a partnership between the local community and a medical practitioner in the provision of a methadone prescription service. It offers methadone maintenance to those requiring that service and a gradual detoxification programme. In establishing this service and having gained community support for the initiative, CARP had a number of organisational, technical and administrative obstacles to overcome.

First, CARP had no funding of its own and could not subsidise the costs of medical fees or prescription fees. Participants would have to pay the doctor and pay the pharmacist themselves. CARP could not provide a premises and so sought and gained the support of the Killinarden Community Council and the South Dublin County Council to arrange temporary accommodation. This was provided in the Parish Community Centre at ground floor level. Liam O'Brien put himself forward as a full-time volunteer until such time as funding was available to pay a co-ordinator. An application for funding was made to the Eastern Health Board in late 1995.

In relation to funding, the relationship with the EHB had been problematic. There was no response to initial requests for funding. CARP decided to become involved in political lobbying to speed up their application. One year after the service was established, the EHB agreed to provide funding to the tune of £25,000 for 1996. The first tranche of £15,000 arrived in October 1996 and the second in the Spring of 1997. A request made in the Spring of 1997 for part-funding for the provision of portacabins was successful but CARP were not informed officially in advance of receiving the cheque. CARP is involved in ongoing discussions with the EHB in relation to the provision of a treatment service for which they have allocated resources in their 1997 Service Plan. Each draw down of funds allocated has been preceded by political lobbying.

Second, in establishing the prescription service, a rational system of screening had to be put in place. Analysis of urine samples taken at a treatment service provides medical practitioners and service providers with a systematic check on the drug behaviour of participants. This would have to be organised in such a way that it was done without the cost of hiring personnel and as such would rely upon volunteers. The screening process put in place in the early stages was counterproductive. The doctor hired a porter from a clinic on a sessional basis to collect urines from the Fettercaim programme and deliver urine samples to the laboratories at Trinity Court for analysis. The results would then be sent to the doctor's surgery at Leonard's Corner. The doctor's secretary then had to select manually, from all sample results, those which were pertinent to both Killinarden and Fettercaim. Thus, samples taken at the end of a week would not be reported upon finally until the middle of a second week following the taking of the sample, i.e. the sample-result time took 12 days. Initially, the taking of samples posed logistical difficulties in that the CARP premises were not entirely conducive to such practices. Also, there were philosophical and ethical difficulties which both participants and volunteers had to overcome in taking the supervised urine samples. CARP wrote to the Director of the Drug Treatment Centre Board at Trinity Court requesting the provision of a speedier testing service. A month later the request was refused. Following liaison with staff at the laboratory in relation to particular results a better system evolved. This involved taking the samples directly to the laboratory from where results would then be faxed directly to CARP. In addition, the process evolved in such a way that the laboratory began to provide bags and bottles for the purpose. Since this evolved the relationship between the programme and the laboratory has been constructive and business-like. The results of samples taken on a Thursday and the following Monday are faxed by the next Thursday and so the sample-result time was reduced from 12 to 7 days.

Thirdly, the programme had to find a way of ensuring that prescribed methadone was taken as it was intended and that building up of or selling of surpluses did not occur. Moreover, a system had to be found where users could

be trusted with large supplies of methadone. A decision was taken to have a system of 'honest brokering' where a concerned other would act as sponsor to the participant. The sponsor would act as a person to collect and administer the methadone at agreed times, and would play the role of a contact person or support within the community. The CARP team would reserve the right to appoint sponsors although they were typically nominated by the participant wishing to join the programme. In some cases, members of the participant's family would act as sponsor. These have been a critical and essential resource to CARP and have given it a unique character. Sponsors maintain a link with the programme as required and must attend a monthly meeting. Being a sponsor requires a degree of regularity and patience.

2.4 Organisational Developments

While the initial task of CARP had been focussed on establishing a treatment response its organisational development has been happening at a slower pace. A member of the voluntary team who acted as co-ordinator assumed the role in a paid capacity in October 1996 as funding became available. The responsibility for clinical and medical matters had always been vested in the doctor. The team could provide essential feedback in relation to the effect of clinical decisions at community level - for example, in relation to screening procedures or if it was known widely that some participants were also buying and using heroin. The team took responsibility for financial matters as funding became available.

As the programme began to develop and to gather resources and funding from outside, the role of the team had become less clear. Additional staff had become available to CARP through the CE scheme and the Jobs Initiative. In the November 1996 to summer 1997 period, the organisation took on:

- a secretary/receptionist;
- a counsellor on the Jobs Initiative Programme who left after three months;
- a support worker to undertake work with participants and to provide health promotion interventions.

Also in this period, a group of women who had come together in 1995, and who had remained closely associated with CARP, subsequently developed their own programme and opened up an independent channel of funding.

The team's role in setting staffing policy in relation to the design of job descriptions and related recruitment tasks did not develop evenly with the new staffing responsibilities it had. Much of this was taken up by the co-ordinator who was anxious to avail of additional resources and to take-up opportunities as they arose. Moreover, with the appointment of additional workers who would act as supports to participants or to undertake administrative and secretarial responsibilities, the role of the team vis a vis participants became more removed. This left the team members feeling anxious and tense about their position. As such, CARP as an organisation had reached a crisis point during summer 1997. This has largely to do with the absence of an objective view of where the organisation had been going or without the benefit of a facilitator to help the team, the doctor and the co-ordinator to reconceptualise their roles. In addition, CARP as an organisation does not have a set of agreed objectives, a vision or a shared philosophy and as such has largely been driven by the need to complete one main task – the establishment of a service to prescribe methadone to drug users who require it. The team lost its initial function when staff began to be appointed. Many of the decisions taken by staff were taken in the absence of a group responsible for setting organisational goals, objectives, policies and procedures.

In sum, the development of the programme and that of the organisational structures and roles have not been moving at the same pace. Those interviewed for this review were committed to renewing the organisation and were wholeheartedly committed to developing new organisational structures despite the apparent difficulties. Many organisations go through similar development cycles and CARP is by no means unique in this regard.

2.5 Organisational Direction

Those consulted by the evaluator felt that there was a need for clearer lines of accountability within CARP. The appointment of the co-ordinator was made by contracting him on a self-employment/consultancy basis. This has advantages and disadvantages. The key disadvantage expressed by team members was the blurring of lines of accountability. Some of those interviewed felt that there was a need to incorporate the views of everybody involved including those who use the service, the doctor, the staff, the community, the state agencies, the Tallaght Partnership and independent people. As such a structure has to be found that can allow the staff to get on with carrying out their duties and to enable them work constructively and creatively and at the same time have a forum in which to agree a vision, to set goals and to work together to meet these. Those involved in CARP have given rise to a new way of dealing with the drug problem and the model adopted raises major questions for how drug use is tackled at community level (see section 4).

3. PROGRAMME ASSUMPTIONS, GOALS AND OBJECTIVES.

3.1 Programme Assumptions

In adopting as its core strategy, the provision of methadone maintenance, the CARP programme essentially adopted a harm reduction approach to the drug issue in their area.

The underlying assumptions were, de facto:

- that problematic or chaotic heroin use was harmful to the individual users;
- that this use was also detrimental to the families of which they were members;
- that such use was detrimental to the safety and well being of children in the care of drug users;
- that problem use is damaging to the community and damaging to the individuals as community members and as citizens.

The provision of methadone maintenance by a physician based in the local community would then act as a means of reducing the harm caused to individuals, families and to communities. Methadone, as a substitute chemical allows the drug user to reduce and to control craving for heroin. As such, it reduces the compulsion to steal or to engage in an endless chase for cash to buy black market heroin. It is assumed that this imposes order on a potentially chaotic situation. Drug users disengage from participating in community life in that they breach community norms leading to disputes between users and other members of the community. In a document circulated by Liam O'Brien in December 1996 the philosophy of CARP is outlined as follows:

Our philosophy is to walk with people as they move from a life dominated by drugs to a life dominated by the normal cares and concerns as mothers, fathers, sons, daughters, partners etc. The medical model that we follow on the programme is high dosage and long detoxes as well as maintenance. We would argue that once a person settles on methadone – a

highly addictive drug - that the 'chase' is now gone from their lives – the waking up and wondering where and how they will get the money and where they will get the heroin - that the other problems that they refused to face or weren't able to face now surface and they have to deal with them. To suggest that they should deal with personal and psychological problems while at the same time doing a detox is contradictory to our minds. Medical research also suggests that after one year 90% of people who have done detoxes are back using heroin. Being a community based response to drug use we cannot throw people off the programme or watch people stumble back into drug abuse and pretend it doesn't affect us. It does. Our community based programme is not a factory where we put people on one end and either cure them or discard them as hopeless as they pass through on a conveyor belt treated by the different experts to emerge as new human beings at the other end (O'Brien, 1996: 2).

3.2 CARP Goals and Objectives

As in section 2.3 above, CARP'S goals were led by the need to deal with a problem in a pragmatic fashion. Thus the central goals of CARP since 1995 have been:

- to normalise the drug issue and to create a rational community response;
- to establish a methadone prescribing service and a support service to drug users in advance of the establishment of a statutory service in the area;
- to normalise drug users and to reinforce and support them in their roles as mothers, fathers, sons, daughters, brothers, sisters, partners;
- in relation to treatment goals, the programme aims to create physical/biological stability and hence to enable participants to achieve social and economic stability.

In achieving these goals, CARP established some key objectives. These have been:

- to provide support to families of drug users and assist in establishing a

self directing group for parents of drug users;

- to provide additional support in the form of counselling, group meetings and social activities;
- to provide a space within which a medical doctor can have access to patients from Killinarden;
- to provide, for those seeking treatment, access to a medical doctor for methadone maintenance and detoxification;
- to secure a suitable premises for the service and for the future development of CARP - Killinarden.

3.3 Treatment

The key treatment tool in CARP is the provision of methadone maintenance. The dosages tend to be relatively high. The doctor's treatment philosophy and plan is based on the notion that participants should be given a sufficiently high dosage so as that they no longer have to 'top-up' using street methadone or heroin. Thus equilibrium is reached based on a medical assessment and upon what the participant feels he or she requires in order to stabilise. This is a *negotiated process* and stands in contradistinction to other treatment approaches that operate on the basis of a *prescribed order* in which participants must adhere to strict medical regime in relation to dosages and treatment policies.

Treatment in CARP, assumes that the participant of the service takes responsibility for achieving some stability in chemical / biological terms by accepting to remain free of substances other than methadone. The participant is then given the opportunity to achieve social stability in what is intended to be both a 'grounded' and 'culturally appropriate' context. The doctor's treatment programme rests on the assumption that social stabilisation is a generic task and can be performed by non-clinical staff. More appropriately, local people from the participant's own social and cultural context are the mediators of 'grounded' rehabilitation⁴.

Thus, a key assumption in the CARP approach is that participants will reach a

⁴ Interview with doctor. CARP has never stated that is a rehabilitation programme or that it's intervention is about rehabilitating drug users.

stage of satisfaction with the dosage they are on. Some will remain at this level. Others will decide to reduce or to eventually abstain and CARP is also available to the participant once he or she decides to 'give it up'.

3.4 Issues from the Interviews With Programme Participants

Semi-structured interviews were conducted with participants of the service. The interviews focussed on what participants determined to be the issues and outcomes for themselves. Interviewees were asked to comment as to what they thought the benefits of the programme were, how it could be improved and strengthened. In addition, interviewees were given the freedom to be critical. This section outlines some of the issues.

3.5 Benefits of the Programme

Generating Awareness

A key benefit of CARP for some is that once stabilised they develop a 'critique' or an awareness of the social relations of heroin use. Moreover, chemical stability plus contact with the programme gave participants the ability to resist heroin. One participant suggested that because he was stable he was able to tell a friend who offered him heroin for free that he that he did not want it because 'I knew that all he was interested in was his money at the end of the day'. The same CARP participant remarked:

“[I said to him] fuck it away if you want, because I don't need it anymore. I got kind of a buzz then. He was on a sick'ner”.

MB: “What was the buzz about”?

“I had me power back... me will power”.

Awareness of Consequences

Participants generally viewed the programme in positive terms and were clear that it had rid them of the need and compulsion to get money to buy drugs. Moreover, it enabled them to look closer at the consequences of their behaviour

for others, especially those who care for children:

“[CARP] helped me to see what kind of a mess they [my kids] were in. (...) There’s a lot more communication with my kids now”.

Openness and Flexibility of Service

Those interviewed all reported that they had initial difficulty in stabilising. In most cases they were able to go back to the doctor to renegotiate their dosage. In some cases where this was appropriate it was granted. This openness proved favourable with participants. Some participants had been on detoxification programmes at Trinity Court but on each occasion had returned to using. For most, it was because they had no intention of giving it up, for others because the detox was not sufficient to enforce an abstinent state:

“I thought that after the eighteen days I’d be okay, but it just got worse. I was still sick. The pains got worse. I just couldn’t stand it any more. (.) I just couldn’t stick it. It was just kept on getting (..) getting worse and worse and so that’s why I went back on the gear”.

One interviewee suggested that there is a *window period* in which his body was trying to adjust to the methadone but wanted heroin in which the support offered by his family and the sponsor to whom he had access to via CARP helped significantly:

“That’s because your body wants heroin. You’re a heroin addict not a phy⁵ addict. But I had a lot of support from my sponsor and from my family and so I managed to get stable that way”.

Achieving a Sense of Normality

Interestingly, many of the participants on the CARP programme are able to access work while being maintained on methadone. When asked what they felt they were aiming for, participants for the most part indicated that they wanted to ‘be normal’, ‘get a job’, ‘independence’, ‘get a car on the road and get work’.

⁵ Commonly used term meaning physeptone, another name for methadone.

For one participant being normal and able to have a family life was crucial and that CARP had enabled her to achieve and to enjoy this experience:

“We actually have a fairly normal family life... me life is brilliant, you know? The best it's been in years”.

MB: “Are you enjoying it”?

“Yes, I am. It's, you know, when people ask you what you want out of life, you know, it's just to be fucking normal, you know? And they're looking at you, because some people wouldn't understand you or wouldn't know what you were talking about”.

MB: “What does normal mean to you”?

“Em, just having a happy and normal life, that's all. That's all I ever wanted, you know? To get married and have kids, you know? Have a nice house, you know. And it's all happening, you know?”

Financial Aspects

Being on the CARP programme was also seen as being cost effective by some albeit that paying for the service and for the methadone was viewed negatively. The weekly cost for a person on a daily dosage of 250mls (1750mls per week) on the CARP programme is £71 (£60 for methadone and £11 for doctor's fee). Self maintenance on black market methadone varies but according to those interviewed it is about four times as much as the CARP programme. The equivalent dosage per week on the black market is £240. The cost of being maintained was seen by some as a net saving and as they did not have to get extra money there was no incentive to steal.

3.6 Participants' Criticisms of the CARP Programme

Financial Aspects

Those who saw the financial aspect in negative terms were of the view that the service should be available to those who could not afford to pay. Some parents

have had to use their income to subsidise the methadone. While there is no doubt that the drain on household income is considerably less than it might potentially be if the person concerned was using heroin on a daily basis, this is an issue of concern. Participants avail of a refund scheme from the Eastern Health Board whereby expenditure above £90 per month is refunded every three months or so. Nevertheless, those who are dependent upon social welfare payments are in a vulnerable position given the pressure placed on *weekly* household income. Service users reported that they were under pressure in this regard and that they had to resort to borrowing from their extended families which would be repaid from the refund.

Concerns in Relation to Confidentiality

The issue of most concern was that of confidentiality. Users of the service were grateful to those who set up the programme and especially to the local people who gave it support. However, it was also felt that there was potential for other people using the centre and members of Killinarden Action Against Drugs⁶ (KAAD) to ‘know more than they need to’. This is a crucial issue for CARP especially in terms of its relationship with those who are seen to be close to KAAD. It is hard for users to reconcile

- (i) their liking for the fact that people have shown solidarity with them in setting up the programme with
- (ii) the idea, as they see it, that there is the potential for personal information in relation to urine results or general performance on the programme to be leaked and used in another context⁷. Service users were not in favour of having to walk into a community centre setting as the following illustrates:

Participant: “[people from the area] sitting there looking at you when you’re walking in”.

MB: “How does that make you feel”?

Participant: “I hate it. I fucking hate it. I always did hate it. I’d

⁶ A group of concerned people active against the sale of drugs in the Killinarden area.

⁷ Such as in general comments outside the centre or at public meetings held to discuss the drugs issue.

rather we got out of here. They're (at the drugs meetings) standing up and all for marching on people's houses yet there's still a shortage of sponsors on the course [CARP]".

This is a crucial contradiction of the CARP Programme. The programme is operating in a premises which most people agree is unsuitable for its purpose, yet it is trying to *normalise* the drug issue and drug users. Thus, it is caught in a tension between trying to maintain participant confidence in the programme and ensuring confidentiality so as knowledge is not used as power against particular individuals. Whatever about the actualisation of some of the fears of drug users, the *potential* exists for power to be used against them and that CARP may in some way contribute to this. This has to be a developmental priority for the programme in the future in that to maintain the confidence of drug users it has to make safe the space they use.

Contradictions

Being 'marched on' is a great fear for those involved with CARP (as it is for the staff of CARP). Two individual interviews gave a consistent view of a sequence of incidents which illustrates this contradiction. CARP contracted an arts group to engage some of the participants in creative activities. Posters that were made were used in anti-drug pusher marches and as one interviewee describes it:

“[we were] making all these posters and masks, all this. And apparently when they went out marching, the things that the people on the programme made, they were going around holding it, marching. Like they marched on half our friend's houses. Some of them were on the programme. They went out and marched on their houses. We all said “fuck you; you never told us what these were for, and you're going around marching on our friends houses and we're after making them. Like, everybody just stopped going to them [activities] then”.

3.7 Needs and Gaps in the Service as Identified by Participants

More Active Participation

Users of the services were unequivocal in suggesting that being involved in CARP should mean more in terms of their participation. One interviewee suggested that participants wanted more from CARP and that the programme should create opportunities to give them effective participation by involving them in a wider range of activities and consulting them in relation to programme planning. There was a sense that turning up and giving urine samples or ‘just doing a piss’ was at best offering very little or at worst seen as being a form of surveillance.

Gender Specific Issues Identified

Women drug users interviewed felt that it would be important for the programme to consider the role that they play as mothers / carers and as such for them to effectively participate a creche facility would be useful. The provision of such a service could well dovetail with other social economy developments in the Tallaght area. Women participants expressed anger in interviews with the policy of the statutory services, that if they were pregnant they would have to travel daily to attend Trinity Court for a lower dose methadone programme⁸. This was seen as being disruptive of family life and tiring for women in that they would have to take a long bus journey on a daily basis.

⁸ Essentially, a policy exists whereby pregnant drug users are referred to central services. This has the net effect of debarring them from participation in community programmes such as CARP.

Weekly Group Meeting

There were mixed views expressed in relation to the weekly group meeting. Some felt that it was very difficult to establish trust between participants and as such felt it hard to participate. Others who have stuck with the group are much happier with it now in that there has been some recreational and creative activities which seemed to reinforce the group. A similar group process might be established with those willing to become involved. This may require commencing a new group each time rather than trying to fully integrate into an existing one.

Counselling and Sponsoring

Participants who availed of a voluntary counsellor were very satisfied with this service. A full-time counsellor was previously available to CARP on the Jobs Initiative but this service only operated for a period of three months. Participants generally reported positively on the *sponsor system*⁹. At times this gave them much needed support. This is an area which should be maintained , and developed.

In interviews participants identified a range of interventions which they felt would provide them with additional supports including counselling, training, education, advocacy, family support, recreation and creative activities.

3.8 Conclusion to section 3

CARP has moved towards realising some of its objectives. Interviews with participants reveal that they are stable and can engage in relationships in their families and their communities in a less problematic way. By using key local supports as sponsors, the CARP programme has made a significant contribution towards normalising drug users and this process should be strengthened and developed. Service participants also want more from CARP in terms of social, educational and vocational development. The normalisation process is undermined given that participants have fears about the role which some community activists play in the area and do not favour them being too close to the programme.

⁹ See section 2.3

4. DEVELOPING A MODEL FOR KILLINARDEN

4.1 CARP and the Community

CARP has been very effective in mobilising a community led treatment initiative. From the outset, CARP was driven by key community activists in the Killinarden Community Council (KCC) and the West Tallaght Combined Residents Association. Initial members of the team were involved in a very 'hands-on' way since the KCC established a sub-committee to look at the need for a drugs service. Consultation with the community was key in gaining legitimacy for the service. On the basis that participants of the service have raised concerns in relation to confidentiality, the programme needs to reconsider its role in relation to the local community, its position within it and how it contributes to community development in Killinarden. This might require restructuring CARP as an organisation.

'Community members have been on the CARP team, they have acted as sponsors or have availed of the service. The new structure might reflect this. Consultation in a community context is difficult given that the users of the CARP service see themselves as members of a community while non-heroin using members of the community see themselves as the only legitimate members. A balance might be struck here. This places CARP in a dilemma which might be resolved by rethinking the consultation process. The credibility of CARP with users of the service, the community and the agencies places it in an ideal position to develop an innovative response here.

4.2 CARP and the Treatment Agencies

The EHB as the statutory agency responsible for the provision of services in relation to drug users has planned to establish a satellite clinic in the Killinarden area. CARP and Dr. Madani are presently negotiating this development with the EHB, This requires a rethinking of the role of CARP especially if the treatment aspect of the programme becomes usurped into the EHB services. CARP are at a point in their development where the option is open for

developing other innovative responses in the drugs area. Gaps exist in relation to the provision of support services to drug users and their families which a methadone programme might not provide. As such CARP is at a point where change and development is required if it is to meet the broader needs of the participants and to optimise the service plans of the EHB. On the understanding that an *arrangement* will be made between CARP, Dr. Madani and the EHB, it is best for all concerned to view the methadone prescribing service as being but one element in a programme which involves other aspects, including counselling, advocacy, recreational activities, social development, education and training.

4.3 The Local Drugs Task Force

Interviews with various agencies in the Tallaght area indicated to the evaluator that CARP has been an effective broker in relation to the development of services and responses. It has been a strategic player and a key contributor to the Tallaght Local Drugs Task Force established under the Ministerial Task Force on Measures to Reduce the Demand for Drugs. Along with other similar initiatives in the Tallaght area, it has been effective in winning recognition for the local neighbourhood approach which is central to the strategy of the Tallaght Service Development Plan. For its part, CARP has been included in the Development Plan for funding to expand its service, develop a counselling service and provide additional supports.

4.4 Rehabilitation Model

Whether a rehabilitation model, a support service or community drug team should be established and what form it should take is the key developmental decision facing CARP at this point in time. A rehabilitation programme is planned for the Tallaght area and will involve various local services feeding into its development. CARP'S strength as a group embedded into the local community might best be optimised by looking at the applicability and viability of the Community Drug Team (CDT) model as developed successfully in the Rialto area of the City. CDTs are now being established in local neighbourhoods around the South Inner City area. This is a hybrid model: part

drugs agency and part community development initiative. Its primary aim is to mobilise a range of non-specialist practitioners, e.g. community workers, social workers, public health workers, general practitioners, probation officers, towards providing supports to drug users and their families (see Bowden, 1996). Experiences with this model have varied largely resulting from the difficulties which the partners in each of these organisations have in working through the partnership process (Forrestal, 1996).

4.5 Structures, Staffing and Resources Required

Most groups or organisations which are established in a community setting begin with voluntary members. They thrive on the energy and commitment of the founders. CARP has overcome the initial hurdle of establishing a treatment service. That service is up and running and CARP faces a process of renewal. The structure of CARP needs to perform the following functions at present and into the future:

- planning and development of core services of CARP;
- development of appropriate policies for treatment and support services;
- selection and recruitment of programme staff;
- community consultation in the area and participation in CARP management;
- develop policies for CARP as a local community organisation;
- accounting for all financial matters relating to the programme;
- provide protection to the assets of CARP and to trade as a company limited by guarantee.

CARP is to establish a company limited by guarantee. To embrace change and to engage in development of the programme CARP will need to rethink its management structure. This might involve having a management committee to deal with policy, administrative and staffing issues similar to that of Community Development Projects (CDPs). Moreover, the management structure has to be sufficiently inclusive so as to incorporate the views of the local community, the programme staff, the medical service, programme participants, the EHB and the

other agencies involved in the programme.

If CARP is to expand and develop, this will have staffing implications. Staffing requirements are dependent upon the model that is adopted. If CARP expand to become more involved in providing supports to drug users and their families, and working in a community development framework then the following human resources are typical of what is required for such an initiative:

- (i) **Community Drug Worker I:** responsible for provision of counselling, advocacy, family supports, training and development of sponsors;
- (ii) **Community Drug Worker II:** responsible for providing community development supports involving:
 - liaison with community groups, schools, Youthreach, training workshops etc. in relation to the drug problem;
 - establish links between CARP and other service providers, research organisations and training bodies;
 - network with statutory agencies, Tallaght Partnership and Drugs Task Force;
 - engage in the development of policies and strategies as part of a team;
- (iii) **Team Leader/Co-ordinator:** responsible for overall development of the programme, supporting and training the management committee and have general responsibility for:
 - day to day management;
 - managing the public affairs of CARP;
 - supervise and support staff;
 - reporting to the management committee on matters relating to the Programme.

In relation to current premises, it is widely agreed that this arrangement is entirely unsuitable for CARP. The Programme has acquired financial support and a site to erect portacabins which offer the possibility to consolidate the existing programme and to develop new interventions.

5. *CARP IN BROADER CONTEXT*

5.1 Communities in the Treatment Services

CARP has demonstrated that local community organisations can effectively mobilise and manage a treatment response. CARP developed at a time when communities were being mobilised to protest against the siting of Health Board clinics in their areas. The ability of CARP to establish legitimacy and credibility and to consolidate its service in a turbulent and potentially hostile context has to be given due recognition. CARP has demonstrated that communities do have a role to play in the development and management of treatment services at this level. The Programme was an attempt by a local community to organise its treatment service in the absence of statutory provision. Its next task was to tackle administrative and technical difficulties associated with the provision of a methadone programme. Once these have been overcome, initiatives of this kind are in danger of stagnating. The challenge is then to reinvent and expand the model.

The response from state agencies, particularly the Eastern Health Board was slow in the initial stages. The EHB has since undergone a restructuring in relation to drugs services. To maintain the momentum of the initiative, the funding provided by the Eastern Health Board was essential to CARP'S survival and development. It had been in operation however for over one year before this funding became available. The groundwork has now been done for a partnership between CARP and the EHB in the provision of a broad based model together with the satellite clinic operation.

5.2 Implications for Local Service Provision

There has been a policy vacuum in relation to drug use in Ireland. The vacuum has been precipitated by the reluctance of the State to depart from its 'war on drugs' rationality (Butler 1997). The State has assumed that a medical framework for developing services has been sufficient. The 'drug, set and setting' framework developed by Zinberg (1984) introduces a degree of relativity to drug use as a medically dominated issue. The medical model

emphasises the 'drug' as the causal agent and as such the response to drug use is a technical one - e.g. methadone maintenance and detoxification. Understanding the 'set' (individual attitude or predisposition) and the 'setting' the social, cultural, economic and political context of drug use allows for a broader dimension to be incorporated into the analysis and the responses to drug use. For its part, CARP has been working at the level of the 'drug' and in organising the technical response for itself. It has also been involved at the level of the 'set' in providing a part-time counsellor and group development. The challenge is to develop a wider response in dealing with the setting or the environmental context for drug use. In order to intervene at this level, local initiatives like CARP require the direct support of statutory and local development institutions to effect a multi-dimensional approach. This requires a commitment from state agencies and communities to working in partnership and to commit themselves to this practice even if this is a difficult process to work through.

6. CONCLUSION: ISSUES AND RECOMMENDATIONS

6.1 Issues

6.1.1 Point of Delivery' of the Service

From an early stage, those involved in establishing CARP realised that only a locally based service dealing with those resident within the immediate area would win the credibility and legitimacy of the local community. At a time when establishing district based clinics has been problematic for the state, CARP has found a successful mechanism for normalising such services. The point of delivery of the service is crucial - i.e. at the point of residence. This has allowed CARP to remain close to the social context in which drug use occurs. Access to the CARP programme is a crucial first step for drug users as a group of people who experience social exclusion, even within their own community.

In addition to the above, CARP is an interesting development in the way it has demystified the medical treatment of drug use. The availability of a doctor who can assess and prescribe appropriate dosages of methadone outside of an enclosed medical hierarchy is a great challenge to the participants, the local community and to the institutions of medicine. However, at the same time, CARP has yet to be successful in breaking the 'methadone as cure' myth as perceived in the local community.

6.1.2 Need for Reconceptualising the Programme

CARP was established based on the voluntary effort and commitment of its founders. It reached a crisis in Summer 1997. The demands on the service from both the state and service users require that CARP moves on. The methadone prescribing service which it set out to establish is now running on a relatively firm footing. The group needs to reconceptualise itself in the light of changes in the organisation and in new changes in how the service is delivered as it becomes part of the EHB's system of services. Moreover, programme

participants interviewed in the course of this review wanted more from CARP than just a methadone prescription service. This is a challenge to CARP to develop the activities which it has experimented with such as aromatherapy and relaxation, counselling, group work, recreational activities and leading to more structured training and education as developed by other projects for drug users, such as the SAOL Project, the Ana Liffey Project and the Merchants Quay Project. Such programmes might be delivered by CARP itself or on a regional basis¹⁰ with other community drug initiatives.

6.1.3 Innovating

The establishment of CARP was itself an innovative process. Key innovative elements here are:

- the location of a treatment centre within the local community;
- the partnership with a medical practitioner;
- the sponsoring system which involves local community members in providing crucial supports to drug users.

These have been critical elements in achieving the goal of normalising drug users in their own communities.

The role that local communities play in developing treatment and rehabilitative responses at this level is largely an untapped potential. CARP consulted initially with the community through the Community Council and it has recruited a team of local volunteer sponsors who play a crucial role in implementing the programme. Both of these elements require development. Participants interviewed were also keen to see the range of support services expanded. This is an opportunity for CARP but one that has implications for the structures and resources of the organisation.

6.1.4 Paying for Methadone

Participants have had to pay for methadone and for the doctor's service from their own income. Those using the service view this in both positive and negative terms. Those who can afford to pay see the CARP service as a cost effective one. Apart from the fact that expenditure is refunded every quarter,

¹⁰ The term 'regional' in this context means with other drug task forces in the south and west of Dublin.

the cost of maintaining oneself on methadone is a drain on *weekly* household income. This may in turn have a negative impact upon nutritional status, general health, fuel and leisure expenditure. Participants in the Programme who are unemployed or dependent upon social welfare reported that they were under constant financial pressure. Such pressures may in turn have a negative impact on ability to remain methadone stable. Participants rely upon relatives for borrowing money which is paid back from drug scheme refunds. The establishment of a statutory service in conjunction with CARP will bring participants in line with other service users in the rest of the City who can avail of free services from local general practitioners or from a treatment centre.

6.1.5 Structures and Accountability

The structure of CARP has been largely undeveloped. It is under strain at present, resulting from the growing need to staff the service as it begins to innovate. Some decision making has to be delegated. The need for restructuring is inevitable. Concerns about who is accountable to whom have to be addressed in this regard.

6.2 Recommendations for CARP

6.2.7 Restructuring, Policy and Accountability

CARP should establish a management committee comprised of all relevant stakeholders in the programme. This should be separate from the proposed limited company and will be responsible for the overall development of CARP as outlined in section 4.5 of this report. The management committee will be a forum for policy making for the Programme and will build on the success of the early development stage and should incorporate key personnel presently active at team level. The 'team' would then be comprised of those whom the management committee appoints to undertake the day to day work of implementing the service. All members of a new management committee should commit themselves to a process which will involve training in management and community development.

Those presently part of the CARP team should avail immediately of an organisational facilitator/trainer to assist the team in:

- reflecting on the service and the implications of establishing an alliance with the EHB in providing a satellite clinic operation;
- re-examining the service and the options presented for the development of the model. It is suggested here that the community drug team (CDT) model which integrates service provision and community development might provide a basis for exploring appropriate methods and strategies;
- reflecting on and developing new strategies for engaging the community in the programme and in such a way that participant confidentiality is not compromised;
- identify the steps in putting together a management committee.

6.2.2 Staffing and Funding

In light of this CARP should then address the staffing situation and recruit appropriately qualified, experienced personnel to develop the programme, and should seek additional funding for such staffing from relevant statutory and other agencies - EHB, Department of Justice, Department of Social Welfare, FAS, the Tallaght Partnership etc.

The management committee should be responsible for recruiting staff and all staff should be employees of CARP-Killinarden.

CARP is developing an innovative model which involves local community members as sponsors. There is a need to develop the community dimension as a very essential part of the innovative process. As such this should be resourced by an appropriate staff member to provide training and development resources to sponsors. The provision of direct supports to participants is a critical dimension to be developed and it should have an appropriately qualified worker assigned to it.

6.2.3 Evaluation

CARP could also engage a long term evaluator to work with the management

committee and staff in developing its analysis, writing up key development phases of the programme and drawing out key issues.

6.2.4 Consultation, linkage and networking

CARP should engage in ongoing consultation with the community and should develop an appropriate forum for this. This should go some way to allaying the apprehensions and fears of participants in relation to confidentiality. Methods of involving programme participants in making policies for the programme should also be built upon. This should involve including a representative of a service users' forum on the management committee.

6.3 General Recommendations

6.3.1 Community Health Approach

CARP is an experiment in locally grounded health promotion. This process requires state investment. A more thorough analysis of *health and social gains* to be derived from initiatives such as CARP would be a welcome step in developing new cost effective, democratically run and community focussed health interventions.

6.3.2 Investment in the Sector

Intervention at community level has been effective in the CARP programme. CARP was forced to innovate in the policy context which was not immediately responsive to such innovation. Investment is required in this new treatment sector in terms of management training, research and programme development.

6.3.3 Pilot Programme

CARP has developed by working outside of the policy context. To utilise this experience and to explore a new context for policy and practice, the Government should consider the establishment of a monitored 3 year pilot project to develop a new community based model for effective intervention in relation to concentrated, problematic drug use.

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