

**Supporting Families through Partnership:
Eastern Health Board (Area 5) Community Drugs Service**

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INTRODUCTION

Introduction and Background to Evaluation

Following agreement between the EHB and the Children's Research Centre, an evaluation of the Community Drugs Service (CDS) was initiated in November 1998. An Advisory Group was established to support the design of the research project and to comment on drafts of the report. The group was made up of representatives of the Children's Research Centre, the Eastern Health Board and two external persons with expertise on issues of child welfare and drug addiction.

The first Advisory Group for the evaluation met on 18 December 1998 and agreed on research goals and methods. It was agreed that the fieldwork would be conducted between December and the end of February, and that the group would re-convene at the start of March to review an outline draft of the evaluation and to refocus. It was further agreed that a full draft would be completed by mid-April. The final meeting of the group took place in late April at which point final changes to the report were agreed.

Goals of Evaluation in Summary

The two main goals of this evaluation were:

- To examine the implications of delivering the service as a specialist service or as part of the mainstream services of the community care team in area 5
- To examine the outcomes for families as a result of intervention by the service (to a more limited degree)

Research Methodology

This report was compiled on the basis of documentary analysis, and data collected from a range of key individuals who deliver the service, liaise with the service, and receive the service.

Preliminary Meetings

Prior to defining questions and issues, and identifying main data sources, a number of preliminary meetings were held with personnel from the EHB and other agencies:

- CDS team leader
- CDS community child care worker
- 4 CDS social workers
- Meeting between CDS team and Aisling
- Family worker in Cumas (community agency)

Data Collection

The main fieldwork for the evaluation was carried out from January to the end of February and included participant observation and individual interviews:

Participant observation:

- Review of two children in care
- Meeting of EHB and Clondalkin and Ballyfermot Task Forces
- Case-work of sub-team members (home visits, access visits)
- Drop-in services, Clondalkin and Ballyfermot
- Meeting between CDS and local community group
- Meeting between CDS and Areas 6 and 7 about setting up a similar service
- Main social work team meeting
- CDS team meeting
- Sessions with community child care worker and child (3)

Individual Interviews–Participants

Management:

Child care manager
Head social worker

CDS team:

Team leader
Social workers
Community child care worker
Fostering social workers
Family support co-ordinator
Family support worker

Local Drugs Task Forces

Ballyfermot Task Force co-ordinator
Clondalkin Task Force co-ordinator
Community representative

Main Social Work Team

Social workers (4)
Community worker

Personnel from Other Agencies

Addiction counsellor, Fortune House
Child care worker, Aisling clinic
Nurse, Aisling clinic
Counsellor, Haven House
Supervisor, Haven House
Home school liaison teacher

Families

Parents (5 mothers, 1 father)
Children (3 children, 2 girls, aged 9 and 13, and one boy, aged 8)

Other data sources;

In addition to data already collected, 2 focus group discussions were conducted to collect addiction information and feedback regarding the emerging issues and findings. The participants in these groups were members of the Community Drugs Service team and team leader, the head social worker, a social worker from the mainstream team, and representatives of the Local Drugs Task Forces. Findings from these group sessions were included in the final report.

In addition, members of the CDS team and the EHB management, and members of the advisory group had the opportunity to read a draft report and give their comments, which were incorporated into the final report.

Terms used in report

| | |
|------|-----------------------------|
| cccw | community child care worker |
| CDS | Community Drugs Service |
| EHB | Eastern Health Board |
| LDTF | Local Drugs Task Force |
| sw | social worker |

BACKGROUND AND SETTING UP OF SERVICE

Background

Opiate misuse in Ireland is predominantly concentrated in the Dublin area, and more specifically, it is a problem for inner city areas and several urban estates. Heroin use has its own history and character, which has developed over the past two decades. The profile of the young male drug addict, living in the family home, involved in criminal activity to support his drug habit has recently given way to an understanding that drug users can also be men and women with their own homes, with their own children and a chronic opiate problem. Alongside this shift in perception has come the realisation that neither the drugs services nor the child welfare services could provide a coherent, effective response without close inter-agency liaison. Existing services found they could only tackle certain aspects of need often with no single agency taking a holistic view of the client. The need to pool information, experience and ideas in order to innovate an effective delivery of service to parenting drug-users has become a key issue for both voluntary and statutory services and the various facets of the Eastern Health Board (EHB). The need for a new model of service provision arose from this gap in services to parenting drug-users and their children. This need for integrated services is reflected clearly in a recent government report

“The drugs problem is what the Strategic Management Initiative in the Public Services describes as a “cross-cutting” issue which cannot be dealt with satisfactorily by any one Department... . If the programmes and services they [the Departments] provide are to be delivered in an effective, efficient manner, it is absolutely essential that practical and workable arrangements be put in place to ensure a coherent, co-ordinated approach.”

(Rabbitte (1996) First Report Of The Ministerial Task Force On Measures To Reduce The Demand For Drugs, p. 11.)

In this report, the themes of interagency co-ordination and local/community consultation were repeated several times. Recognition of the need for an integrated response to this issue gave rise to a proposal from within the Community Care team in Area 5 to set up a specialist service for opiate dependent parents and their children.

The wider context that drug users and their families live in also added to the impetus to set up the service. A new protocol was introduced by GPs and consultants from the Drugs/Aids services in October 1998, which put a limit on the number of drug users that could be treated by any one GP. As a result, many patients found themselves unable to receive drug treatment through their GP. A large number of drug-users who had previously been stable found themselves without methadone and facing lengthy waiting lists for maintenance programs. The impact of the protocol was to change the structure of drug-use, and to negatively impact on work with those drug-users affected. Some drug-users became unstable—many returned to using heroin and began using, and in some cases injecting, tablets not previously used. Street Physeptone also became more difficult to acquire. The situation was compounded by the fact that many professionals were not aware of this change in protocol and may have attributed relapse and instability of their clients solely to individual factors.

Housing is another pertinent issue for drug-users and those working with this client group. The efforts by Dublin Corporation and the County Councils to eliminate “anti-social behaviour” have involved the eviction of a number of families suspected of drug dealing. The effects of eviction can include separation of families, increased instability in drug-use, decreased school attendance by children, and lesser engagement of families with support services. The impact of high levels of transition is often inconsistent and unknown environments for parents and children, and difficulty accessing state services as families move from one catchment area to another.

Other factors impacting on accessing and delivering a service to such families include poor primary health care provision, lack of residential facilities for women with children to detox or stabilise their drug use, and lengthy waiting lists for maintenance and detox programs. In summary, the wider context of drug use in Dublin must be considered in any evaluation of service provision to drug using parents and their children. One worker on the CDS team captured the importance of context, saying “If you’re going to treat someone who has a drug problem you have to take the environment into account.”

Proposal for Community Drug Service

Community Care Area 5 provides a service to those living mainly in the areas of Clondalkin, Ballyfermot and the Canal Communities, which are also areas with their own Local Drugs Task Forces (LDTFs). LDTFs were set up in areas “having the most acute drugs problem and, therefore, requiring priority action” (Rabbitte, 1996).

In early 1997 chronic opiate use by many clients being seen by the service was identified as a major problem for these families and also as an impediment to engaging families. It was perceived that a large number had been forced to leave the inner city under pressure from local groups and had resettled in Area 5. Problems engaging this client group were further exacerbated by ill health due to illnesses such as H.I.V. and hepatitis B and C. Families were often engaged in criminal activities in an effort to procure drugs and many had no permanent accommodation. These mutually reinforcing factors were seen as placing major demands on an already overloaded service and on existing placements for those children who could not remain in their parents’ care. The need for some intervention which could address issues of child welfare and parental drug use in tandem was felt to be a key step in providing an effective service to these families.

Arising out of this recognition of service need a clear mission statement was drawn up by the head social worker in Area 5 to

“strive to provide a social work and child care service to those families with a chronic opiate dependency problem, whose children are also perceived to be not receiving adequate care and protection.”

Intervention was to focus on supporting both parents and children. Children were to have available to them the services of a community child care worker (cccw) who would provide assessments, and would design and carry out intervention plans for therapeutic work through play, art and activity-based work. Parents were to be supported by social workers to create stability in their families’ lives. It was anticipated that this would involve helping clients to access appropriate drugs services and to avail of family support services, to find stable accommodation, and where children are in care, to enable those children to have regular and frequent access to their parents. Furthermore, it was perceived that service providers would need to draw on resources provided by different programmes within the EHB if families were to access the wide range of supports needed. The EHB Review Of Adequacy (1997) identified the key issues for these families as “addiction, child care, health (physical and emotional), housing, criminality and employment” and states that “these issues must be addressed in an holistic and integrated manner if progress is to be achieved” (p. 51).

Therefore, the service arose out of a perception that there was a need for a more intensive and holistic service to respond to a client group who often deal with unpredictability on a daily basis. This unpredictability may take the form of involvement in the criminal justice system, health problems, or homelessness and its attendant transitions. The proposed service was named the Community Drugs Service and was expected to supplement the usual complement of social workers and community child care workers in the area. By April 1997, a service proposal had been drawn up and drafts circulated to relevant parties.

Funding

Funding for this service was sought by the then head social worker, from two sources. The first source was the EHB. Agreement to fund the service on a one-year pilot basis was obtained from the Programme Manager of the Health Promotion, Mental Health, Addiction and Social Development Programme of the EHB in April 1997. It was agreed that two community child care and two social work posts would be funded which would add to the current complement of workers on the Community Care team. These posts were to come under the direction of the head social worker. The four posts were filled between August and November and took up some of the existing work on the wider team of particularly chronic families. Agreement for the four EHB posts to continue to be funded by the Health Promotion, Mental Health, Addiction and Social Development Programme in conjunction with the Drugs Task Force funding was reached in summer, 1998.

The second source of funding targeted was Local Drugs Task Forces. The head social worker wrote to the LDTFs of Ballyfermot, Clondalkin and the Canal Communities in September 1997 to request discussion regarding funding to supplement the existing service with a sub-team in each of the areas. The letter states that

“This service, as it is currently resourced, can only deal with the most serious cases and will not be in a position to provide a preventative service.”

In spring 1998 the Ballyfermot LDTF funded two social work posts and Clondalkin funded one social work and one community child care post. The Canal Communities LDTF had already allocated its budget for the year and was unable to fund any posts. Steering Committees made up of EHB and Task Force staff were established as were two sub-teams to cover the two areas providing funding. It was agreed that funding would be made available for a period of one year. Funding runs out in April 1999 from the Ballyfermot Drugs Task Force and in May 1999 from the Clondalkin Task Force. Co-ordinators of both Task Forces are considering interim funding for a period of a few months until specific funding is identified at government level.

Due to the confusion regarding administrative arrangements for the service, it was decided in August, 1998, that all monies would be channelled through the Children and Families Program, which would administer the service. The service, however, continues to be based in office accommodation provided by the Health Promotion programme of the board.

To date, the CDS team has not been able to employ its full complement of staff due mainly to staff shortages in the relevant areas. At present, the Community Drugs Service exists in structure as two teams, each made up of two social workers and a community child care worker, as well as a ‘floating’ community child care worker. Referrals are on a patch basis, one team covering Clondalkin and the other Ballyfermot. An acting team leader was appointed to the service in one of the social work posts in June 1998.

Consultation and Design Phase

It was reported that from August to December 1997 team members engaged in a process of consultation whereby they met with local community groups, drugs agencies and the maternity hospitals. Details of these meetings were recorded in a diary. This period is characterised as a time spent meeting local groups and introducing the team. There was a consultative element to this process, whereby the team asked for suggestions and input into how best to operate the service.

Consultation about the design of the service also took place with the main community care team in Area 5. In September 1997 the mainstream team was circulated with a questionnaire drawn up by the CDS which requested statistics regarding drug users on their caseloads and also asked for their suggestions concerning the role of the drug/child protection team. However, three of the four social workers on the main team interviewed indicated that in their

view, little input was requested from the main team regarding the design of the new service. Indeed, all three suggested in independent interviews that they ‘may have missed a team meeting’ where the aims and objectives for the service were discussed, and thought that there was no discussion about ideas for the service, or about aims and objectives, with the main team. Workers did report that when the team was set up there was some agreement at main team level for the CDS to work differently and separate to the main team and it was generally viewed as positive. However, the perception of a low level of involvement in the design of the service appears to have led to a lack of a sense of “ownership” of the new service by the main team social workers. This sense of separateness was compounded by the nature of the recruitment process, which is described in a later section.

STRUCTURE AND MANAGEMENT

This section deals with issues in relation to the structure and management of the service, staffing, partnership with the LDTFs and the relationship of the CDS to the main team in Area 5.

The CDS was established as a cross-programme initiative of the EHB in August 1997. The Community Drugs Service is managed by the head social worker, as a sub-team of the Social Work and Child Care Team in Community Care Area 5. The service is administered through the Children and Families Programme of the EHB although funding for posts comes from the Ballyfermot and Clondalkin Task Forces, and the Health Promotion, Mental Health, Addiction and Social Development Programme. It is also important to note that the LDTFs are funded by the Health Promotion, Mental Health, Addiction and Social Development Programme of the EHB. That programme has no direct role in planning or managing service provision.

Structure

The service is divided into two sub-teams, the Ballyfermot and Clondalkin areas each being serviced by their own sub-team. The team leader manages daily service provision. She is available to the CDS team only. In the team leader's absence, the head social worker is available to CDS team members. The EHB line manager for the team is the area general manager.

The team leader is viewed by team members as the representative for the team and advocates their views and decisions to the Steering Groups. As detailed in the previous section, the Steering Groups comprise representatives of the Task Force, the EHB (head social worker and team leader) and an independent person, and were established with the purpose of ensuring effective liaison between the funding partners. The Steering Groups now endeavour to meet every six weeks, members of both Steering Groups having expressed dissatisfaction with the flow of information.

Management of Service Provision and Decision-Making

The team leader manages service provision on a day-to-day basis. Decisions about individual cases are made through consultation between the team leader, social worker and community child care worker (where involved). Formal supervision also takes place. Team meetings are held fortnightly and CDS workers expressed the view that decisions made at these meetings can be implemented quickly. The Steering Groups also have the capacity to make decisions about service provision and to effect such decisions without delay. Indeed, both Task Force and EHB members stated that a key feature of the service was the fact that it was managed at a local level and was, therefore, able to side-step bureaucracy to implement decisions.

Accountability of Workers

This is a difficult and complex area. As social workers carry out statutory duties of the health board they are accountable to the health board for this work. Child protection is a statutory function and must override. The Child Care Act, 1991, Part II, Sec. (3)(1) states that

“It shall be the function of every Health Board to promote the welfare of children in its area who are not receiving adequate care and protection.”

and in performance of this function the health board shall

“regard the welfare of the child as the first and paramount consideration.” Sec.(3)(2)(b)(i).

EHB management clearly views the service delivered as being statutory and believes that, as such, the head social worker has to run that service. CDS team members reported in interviews that they felt accountable to both the EHB and the relevant Task Force. They stated that they assume that if there was an issue raised concerning their practice that this would need to be discussed with the LDTFs as well as the EHB. It is not clear from either documentation or interview whether workers are directly accountable to the Task Forces.

Team members also recognise the need for accountability to be extended to the communities and families they work with, and described themselves as working in an open and transparent fashion to achieve this.

Staffing and Turnover

The team currently consists of a team leader, four social workers, one community child care worker, two fostering social workers, with support from family support workers and a family support co-ordinator.

The perception from the main team and outside agencies is that turnover is relatively lower on this team, but this perception is inaccurate. To date, the head social worker, one community child care worker and one social worker have left. Staff turnover in the EHB is seen by outside agencies dealing with this client group as a factor exacerbating slow responses to referrals. Clients see it as a barrier to forming trusting relationship with social workers. The issue of staff turnover is seen as critical by the LDTFs as they believe that continuity is a vital factor in providing a service to this client group. To encourage greater stability in staffing, the Ballyfermot LDTF has made available funding to the CDS to allow staff to avail of external support and/or counselling. This arose from the perception that there was a high risk of burnout due to the intensive nature of the service. Although the service is attracting staff members who are motivated to work with this client group, and this may help to maintain them within the service, team members perceive the work to be rewarding but intensive and difficult. Management’s perspective is that it is not in a position to require staff to remain in any health board post. However, management can explore with staff ways to provide incentives to keep them in their posts. If low turnover is seen as an essential feature of providing a service to this client group, further steps may have to be taken to discourage staff from leaving within short periods of taking up their posts. Health board investment in training was identified by workers, from both mainstream and CDS services, as a way of maintaining staff in their posts.

Partnership with Local Drugs Task Forces

Partnership was entered into with expectations regarding funding, input into the operation of the service, and monitoring of the service. However, although the conditions of partnership were discussed, it is not clear to what extent they were agreed on. The two LDTFs became involved with funding the service as part of their remit to develop an integrated strategy to deal with local drug problems. Funding was provided on an interim basis in anticipation that the EHB would continue to fund a specialist service for this client group once the LDTFs had withdrawn involvement. The LDTFs saw it as important that funding of such a service in the long term should be provided by the EHB rather than by community organisations.

The Task Forces also expected, however, that while the funding would become mainstreamed within the health board, the service itself would remain specialised for this client group. One LDTF co-ordinator saw this as an explicit understanding with the former head social worker.

The nature of the input of the respective partners into the operation and monitoring of the service, especially that the LDTFs, was not clear initially. This was partly due to the steering

group being slow to start up. CDS team members viewed co-funding as positive and desirable, as it allowed for greater input by community groups about the nature of the service provided locally by the EHB. They believed that this sense of greater local involvement led to an increased acceptance of services at a local level.

Relationship of Community Drugs Service to the Mainstream Team

At the time of interview there were 24 social workers and 3 community child care workers on the mainstream team; of these social workers, 15 were caseworkers, 5 fostering workers and 4 intake workers. The ratio of social workers to community child care workers was 8:1. Three team leaders are available to the main team. The social worker from the main team interviewed for this evaluation had an average of 20 cases at any one time, with roughly the same number of children in care. One of the workers described herself as a case manager having little time for direct intervention with her caseload, and much of her time consumed with office work and access.

Initially the CDS were seen as very separate to the mainstream team: they were based out in Deansrath, and had work allocated directly from the head social worker. Physical distance of the mainstream and CDS teams continues to be maintained, with the CDS currently based in the Drugs/AIDS building, situated about 3 minutes walk from the main social work offices. The teams have regular contact with each other as all social worker and community child care workers attend the fortnightly team meetings, although the CDS has its own team meetings.

Referrals to the CDS are only a portion of the total of child welfare cases featuring opiate abuse dealt with by the area. The remainder of the cases are dealt with by the mainstream team. There is a waiting list for the CDS, which the team leader holds, but any crises occurring with the families on this list are dealt with by the duty system until such time as the case can be allocated. A key difference in practice between both teams is that the CDS have the benefit of working with a protected caseload, i.e. social workers take on cases only when they have room on their caseload. The mainstream social worker interviewed did not see this difference in operation as a source of friction. There seemed to be a consensus in the main team that the CDS should work differently, and that it was better if they were allowed remain apart from the main team. Those interviewed said that on the mainstream team the CDS was generally considered a positive development. When asked to describe the impact of the CDS, one mainstream worker pointed out that there are now four extra social workers to do duty, there is an additional team leader and they can take on extra work. The CDS team appears to be viewed as a positive, as an addition to the resources of the main team.

GOALS AND EXPECTATIONS

Introduction

This section provides an account of the initial goals of the service based on available documentation, and on interviews with key players who provided retrospective accounts of their perceptions of the goals and expectations of the service at the time of setting up. Key players perceptions of the success of the service in meeting its aims will also be outlined. Issues emerging from this analysis include:

- the need to clarify what the current goals and expectations of the service are,
- the need for clarity regarding the ethos, focus and future direction of the service,
- support for the aims and objectives of the service on the mainstream team.

Initial Goals

According to documentation the mission of the Community Drugs Service team is as follows:

“within the context of the Eastern Health Board mission statement we will strive to provide a Social Work and Child Care Service to these families with a chronic opiate dependency problem, whose children are also perceived to be not receiving adequate care and protection.”

The initial goals of the team as set out in their mission statement are:

1. To work as a sub-team within the social work and child care team providing a service to Community Care Area 5.
2. To establish adequate liaison with relevant statutory/voluntary agencies.
3. To provide a service to those families who have a chronic opiate dependency and where the children are perceived not to be receiving adequate care and protection.
4. To take referrals only from Community Care Area 5 social work and child care team leaders.
5. To provide, in liaison with the foster team, a fostering service designed to meet the needs of the client group.
6. To provide in liaison with the family support service a service designed to meet the needs of the client group.
7. To work within the ‘harm-reduction’ model outlined in recent EHB reports.¹
8. To evaluate the service.

It is reported that the head social worker at the time and the first social worker on the team did most of the groundwork around the aims and objectives and the mission statement.

Adjusted Goals

On the basis of an internal review by the former head social worker and the first four workers on the team, the above goals were reviewed in December 1997 and adjusted by the addition of a number of new objectives and some changes to the original objectives. The additional objectives were:

1. To establish a weekly ‘Information and Support Service’ dealing specifically with queries and referrals from various voluntary and statutory agencies as outlined earlier.
2. To act as a resource and advice service to the Community Care team in Area 5 and to the other Community Care Areas.
3. To set up a Child Care and Advice Support Group with CASP. We have agreed to guidelines that will accompany this service. The service will commence in early January.
4. To establish a ‘Prevention and Support Programme’ for the older children of the families we work with.

¹Omitted from internal review

5. To continue ongoing research into the area of families vulnerable to opiate addiction, this will include gathering essential statistics such as: periods of homelessness, imprisonment, take-up rate of established drugs programmes, etc.

In the review, Objective 2, ‘to establish adequate liaison with relevant statutory/voluntary agencies’, had been amended to read ‘to establish *close* liaison with relevant statutory and voluntary *drugs* agencies.’ The objective to work within the harm reduction model had been omitted. During focus group discussions for this evaluation team members stated that while harm-reduction as a goal does not appear in the adjusted goals of the team, it is, in fact, an implicit aspect of the work of the CDS and needs to be made explicit in documentation. The type of harm reduction work carried out by the team in relation to safer drug use includes:

- HIV/hepatitis C education and counselling
- Safer injecting practices
- Contraception
- Other issues including prostitution, safer sex practices, etc.

Perceptions of Aims and their Achievement

(a) Community Drugs Service Team

The CDS members’ perception of the aims of the service were that they are expected to provide a specialist and intensive service to drug-users and their children using knowledge and experience of drugs that are lacking on the main team. Liaison with other agencies is seen as a key aspect to providing a holistic service. To facilitate this way of working, workers are allocated a small caseload. The main aims were perceived to be:

1. supporting families towards balance and stability, and maintaining children within the family,
2. establishing and maintaining close liaison with relevant statutory and voluntary groups,
3. prevention work in relation to drug use and child welfare and protection issues.

Workers and outside agencies shared the belief that close liaison allows for a more holistic approach to the client and a clearer understanding of the issues affecting clients both as a person and as a parent. One social worker remarked that

“As a team we would see that it’s very important to try and link with community groups and drug treatment services.”

Clients are often reported by outside agencies as having requested liaison between the social worker and their drugs worker. There is also the perception by workers that good working relationships are necessary to challenge assumptions about drug users held by some agencies and individuals. This is work that needs to have a positive spin-off for clients and therefore needs to be handled skilfully and in a way that will not adversely affect future contacts. Feedback from drugs agencies, a hostel and a home-school liaison teacher indicated that as a result of frequent contact and the nature of this liaison, social workers are viewed in a far more positive light and close liaison allows for an understanding of the activities of each agency. The emphasis on prevention as a goal of the service became stronger following the internal review.

In relation to child welfare and protection, workers describe themselves as having a preventative focus to their work. Children are linked into a variety of services within the community to ensure that their welfare needs are being addressed. Such services include day-care facilities, child and family centres, home-school liaison service, educational support and youth services. A primary aim of the team in relation to child welfare is to provide regular access, i.e. twice weekly, with a focus on reuniting the family. The CDS workers also prioritise working with and giving support to extended families. It is hoped that the intensity

of this support reduces the possibility of breakdown of placements of children placed with extended families.

The aim of carrying out prevention work highlights the innovative nature of the service in terms of its involvement with community groups. However, there is a need for greater clarity about the meaning of the term “prevention”. For the LDTFs it appears to mainly imply work conducted at an early stage of addiction, usually in terms of advice, information and support, while the CDS, at least initially, focused on chronic drug users. Members of the Task Forces do, however, perceive other work carried out by the CDS as preventative in nature, in that it can help to avoid crises or further drug use. Drop in work and the work of the community child care worker are seen as preventative work. The work of the team with parents and children may also have the long-term outcome of preventing later drug use by children. Further discussion about the nature of prevention can help the partners in this service to achieve greater clarity about their respective aims and aim achievement.

Community Drugs Service Perceptions of Goal Achievement

The December 1997 review states that “after six months in operation we feel that the team has achieved the initial objectives.” The final paragraph summarises the team’s perceptions of its own success:

“The Social Work/Child Care Team has become accepted and established itself in Community Care Area 5. It is providing an important link between the statutory and voluntary drug addiction services and the Community Care Team, in the area of drug misuse and child protection. It uses a multi-disciplinary and eclectic approach in attempting to deal with the problems that surround opiate addiction, thus providing a valuable and intensive advice/support service.”

A number of issues emerged in interviews with team members in relation to achievement of stated aims. Some of the workers pointed out that change in relation to drug users is often slow and that many of the outcomes of the service are practical. One of the reasons for this is that, initially, many of the cases that come to the team are in crisis. At this stage, it is necessary to provide practical intervention before any therapeutic work can be initiated. As a result of practical intervention a trusting relationship may be built between the client and worker thereby facilitating a therapeutic relationship. However, almost all cases now have had a period of stability and the vast majority of drug-using parents are now in treatment. This view was supported by management personnel in the EHB who stated that clients have had an intensive service, with some being detoxed or rehoused. There are still a high number of children coming into care but this was thought to be for shorter periods of time.

Several workers were concerned about what they perceived as a lack of clarity regarding the aims and objectives of the service. They recognised that a new and innovative model of service delivery was likely to undergo a good deal of change, and that there was likely to be a lot of “construction on our feet” and adjustment of aims according to the clients and resources. However, half the workers on the team expressed the view that there is a need for review of the current aims in order to achieve greater clarity as to what the service is now trying to achieve as a team. Concern was also expressed about the discrepancy between workers’ initial perceptions of the nature of the work on the team and the reality. This was viewed as a matter that could be rectified by achieving greater clarity regarding the aims and focus of the service.

During discussion of the aims of the service, the issue of how individual attributes and values can drive service provision were often raised. This issue is expanded on below in the section on recruitment and training.

(b) The Local Drugs Task Forces

In early 1998, the Local Drugs Task Forces in Ballyfermot and Clondalkin became involved with the CDS with the perception that the communities they represented would gain most from having a service with a preventative focus. It was recognised by a key member of the Local Drugs Task Force that the perspectives and emphases of the two agencies entering partnership differed: the health board management emphasised child protection while the LDTF emphasised an addiction perspective. Similarly, a community representative on the Task Force expressed the opinion that the service was not set up to do child welfare work but rather to support drug users with a mix of chronic and earlier intervention cases.

The co-ordinator of the Ballyfermot Drugs Task Force described four principal aims of the service as being:

- to work with parents who are drug-users in an intensive way leading to treatment,
- to support children, keep them in school, in an effort to ‘break the cycle’, and to put into place a support structure for families who are now catering for children of drug-users,
- to make available an advice and support clinic for anyone having worries or concerns,
- to act as a support in the community.

The overall aim was perceived as putting in place support structures at four levels affected by drug use: parents, children, carers and community.

The Clondalkin LDTF, in its Proposed Memo of Understanding stated that

“The focus of the work should be preventative and include work with families of drug users that would not normally come within the remit of the health board.”

It was made explicit that child and family welfare (not just child protection) issues would be paramount. The Co-ordinator of that Task Force expected that the CDS team would:

- focus on casework with drug-using families who had children
- link with services and local community groups
- operate a drop-in service, i.e. advice and support services provided in the community on a “drop-in” basis
- take a minimum of 60% of referrals from Clondalkin community groups

The Task Forces appeared to have understood that their involvement with the service would be on the basis of partnership rather than solely funding. There were initially concerns in at least one of the Task Force areas that the team would work in a crisis way without an emphasis on prevention. The co-ordinator of one of the Task Forces stated that it is very difficult for any project to show its worth in one year, but that the Task Force views the service to be a viable and very necessary service that it is satisfied with. The second Task Force co-ordinator identified the single biggest impact of this project as the improved communication between services on a community level. One outcome of this development was perceived to be a change in attitudes to social workers, in that clients view social work intervention as positive and the community has greater confidence that action is being taken to help families with opiate problems.

A key outcome for clients was identified as how motivated they become to use the drug services well. Increased advertisement of the drop-in services was thought to be necessary to address the under-utilisation of this aspect of the service.

(c) EHB Mainstream Workers

Workers on the main team appeared to see themselves as having little input into drawing up aims and expectations for the new service, and believed that this work was carried out by the

head social worker at the time. This may have contributed to the lack of clarity about the aims of the CDS (see section above on Consultation and Design Phase). However, one of the main aims of the new service was identified as increasing liaison work with other services. One social worker on the main team indicated that she believed the team had adhered to the mission statement and has succeeded in building up liaison with outside agencies.

(d) Outside Agencies

When questioned about the aims and objectives, a number of respondents instead described the ethos of the service, practice orientation and personal attributes of the team. Outside agencies and clients expressed views about what they expected in good practice from a social worker rather than what they expected from the CDS.

Aims and Achievements in Summary

Table 1 below outlines the objectives of the service and perceived success in meeting these, as expressed by the varying groups interviewed and observed.

Table 1: Aims and Achievements

| Initial Objectives | Achievements |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| To work as a sub-team within the Social Work and Child Care team providing a service to Community Care Area 5. | Set up as two sub-teams covering Clondalkin and Ballyfermot only [i.e. not all of area 5] but without full complement of workers. As many families from the area are without permanent accommodation, team works with families who are now in B&Bs or hostels. (see statistics in Table 2 below, p. 25) |
| To maintain adequate liaison with relevant statutory/voluntary agencies. | Perception by agencies that liaison is close and regular. |
| To provide a service to those families who have a chronic opiate dependency problem and whose children are perceived not to be receiving adequate care and protection. | This is the only reference to the dual focus of the service. Many parents engaged in polydrug use. Team currently works with two teenagers, but were involved with three. |
| To take referrals only from Community Care Area 5 Social Work and Child Care Team Leaders and community groups. | Within months of setting up, referrals accepted from schools, drugs agencies, concerned individuals and hospitals. Task Forces stipulated that referrals received from community groups. |
| To provide in liaison with the Foster Team, a fostering service designed to meet the needs of the client group. | Following community consultation, the fostering workers available to the CDS decided a fostering service would not be appropriate and began recruiting for the Family Care initiative in early 1999. |
| To provide in liaison with the Family Support Service, a service designed to meet the needs of the client group. | Clients identify the Family Support Worker as one of their main sources of support. Child care worker did some training with this group. |
| To work within the ‘harm reduction’ model outlined in recent Eastern Health Board reports. | This aim was omitted from the aims reviewed in Dec. 1997 |
| To evaluate the service. | Service was internally reviewed in Dec. 1997. Evaluation by the Children’s Research |

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Centre commissioned in 1998. (continued over) Some team members felt there was a need for regular team reviews and evaluation. |
| Additional Objectives (added Dec. 1997) To establish a weekly 'Information and Support Service' dealing specifically with queries and referrals from various voluntary and statutory agencies as outlined earlier. | CDS workers state that they do carry out this function through two "drop-ins" where they have leaflets available and act as a referral agent where necessary. |
| To act as a resource and advice service to the Community Care Team in Area 5 and to the other Community Care Areas. | CDS workers report that mainstream workers and other professionals do contact them for advice and information. Researcher observed this occurring. |
| To set up a Child Care Advice and Support Group with C.A.S.P. | Community child care worker reported that C.A.S.P. identified a need for the community child care workers input to run a parenting group but due to non-attendance the service was discontinued. |
| To establish a 'Prevention and Support Programme' for the older children of the families we work with. | Not established. Thought by CDS worker to be an initiative, which did not take place due to shortage of community child care workers on the team. |
| To continue ongoing research into the area of families vulnerable to opiate addiction, this will include gathering essential statistics such as: periods of homelessness, imprisonment, take-up rate of established drugs programmes, etc. | Statistics are collected on progress and monitoring forms in supervision both as a way of collecting information and as a way of giving feedback to the LDTFs on operation of the service. |

Focus of the Service

1. *Drug use/Child protection and welfare or child's needs/parent's needs*

The work of the CDS has two foci: child protection and addiction. However, the key players have different opinions as to which focus should take precedence. The Task Forces focus on supporting drug-using parents and their children, while health board management place the emphasis on child welfare and protection. One Task Force coordinator stated that the former head social worker "was coming from a child welfare, child protection perspective when he set up the project. We're coming from an addiction perspective in the family."

The Task Forces did understand at the outset that they were being asked to fund a service that would carry out statutory functions. One of the mainstream workers in the EHB clearly illustrated this potential conflict. She identified the child as the cut-off point in service provision: if the child is at home, intervention is with the parents and child, and if the child is in care intervention is with the child and foster parents. The focus on child welfare on the main team can therefore lead to the exclusion of parents who fail to keep appointments, etc. The CDS was seen by this worker as having two joint priorities; the child and the parents.

There is now a need for documentation to clearly state that the service carries out statutory duties and to outline possible implications, for example that a child's need for adequate care and protection will always override parental needs.

2. *Crisis/Prevention*

As stated earlier, preventative work is not defined in the documentation relating to the CDS. Both documentation and team members describe much of the initial work as crisis intervention. However, the additional service objectives have a more preventative focus than the initial objectives. The Task Forces were quite clear that they wanted a preventative focus to the work of the CDS workers, whom they expected to work with families at all stages of the addiction process. In individual interviews the CDS team members described much of their work as being preventative and reiterated this point during focus group discussions. Working to prevent relapse, for example is described as preventative work, as is drop-in work, harm-reduction work and the work of the child care service. There is a clear need for preventative work to be defined. In particular, it is not clear whether prevention relates specifically to issues of drug dependence or to issues of child welfare and protection. Cases referred to the CDS are in crisis, and the reason for referral is generally child protection issues. On the mainstream team cases can often be closed after the child protection issue is investigated and/or resolved. The CDS, however, continues to work with families around child welfare issues, as part of the process of achieving stability for children and their families, and in an effort to prevent protection issues arising again. The team leader pointed to the value of this approach: “the extra bit of an effort with clients, extended family...can help avoid a crisis.”

3. *Social work/Child Care*

At the outset, the service was to have two community child care workers and two social workers. Funding then became available from the Task Forces to employ a further three social workers and one community child care worker. Since September 1998, the service has been operating without two community child care workers and therefore cannot offer a child care service to many families. This has affected the kind of service which can be provided, especially for children in Ballyfermot who do not have a community child care worker from the team available to them. Initially, the service carried out joint assessments of family needs, but now the social worker, in consultation with the team leader, decides if referral to the community child care worker is needed. A decision is then made in consultation with the community child care worker about the nature of the work involved.

Ethos

CDS workers stated that they needed to make explicit their ethos. Perspectives on addiction and social work influence practice but no reference is made in documentation to the model of practice that influences service delivery. Practice orientation desired by team members are outlined below:

- respect for clients (especially as this client group are perceived as experiencing social exclusion and discrimination)
- clients seen as individuals
- client-centred approach
- to encourage independence
- an interest in working with this client group
- work from a systems perspective
- strive to empower clients.

In a forthcoming team review, the CDS plans to document the theoretical perspectives that influence social work and child care practice. The CDS team also plans to review its aims and objectives.

RECRUITMENT AND TRAINING

There are implications for recruitment and training of staff in providing a specialist service to drug users and their families. It is important to clarify the training required for workers providing such a service, both in terms of skills and knowledge brought to the job and in terms of ongoing training needs. In this section the following issues are addressed:

- Recruitment of workers with specialist knowledge
- Knowledge of drugs issues in the mainstream community care team
- On going training needs of staff

Recruitment of workers with specialist knowledge

The question addressed here was whether it is necessary to recruit staff with specialist knowledge of drug issues to work on the Community Drugs Service. What skills are perceived as necessary to work within the specialist team? The following views were expressed by key players.

a. Community Drugs Service Team

Within the specialist service itself most workers held the view that specialist knowledge, which could be gained through work experience or training, were valuable assets in this demanding work context. While skills and knowledge regarding drugs and drug addiction were seen as an asset, this was not considered to be essential by most workers interviewed. One social worker pointed out that this learning could occur after taking up the position. Another worker, however, believed that a better service could be offered to clients if social workers were not required to do a lot of their learning once they had taken up the position. In her experience, workers were required to learn both about agencies dealing with drug users and about drug use itself. She felt disadvantaged when starting the job to have to learn so much about drug issues.

One of the factors influencing current workers' perceptions of the need for specialist knowledge was the presentation of the focus of the work to incoming staff, and in particular, the degree of relative emphasis placed on community drugs work and child protection work. One social worker on the CDS team said that her perceptions of the nature of the work prior to joining the team were different to the actual nature of the work. She had perceived it to be different to community care (mainstream work) in terms of what was offered to families:

“offering them a higher support service—as opposed to the general community care approach and that it would be specialized, would use the specialist knowledge of drugs awareness.”

Similarly, another worker stated:

“ I realised I was coming to work with families and their children, but the community care aspect...or the child protection aspect...certainly wasn't emphasised.”

There was a good deal of consensus among members of the CDS team that a core requirement for these posts was an interest in working with drug users and a positive approach to drug using clients. Two of the social workers believed that the successful operation of the service depended in part on the training of the team on drugs issues, which had implications for their approach to clients who are drug users. They were seen as more likely to have respect for drug users and to want to work with people who are extremely marginalized. One worker commented that

“Experience means that pre-conceptions of drug-users are dealt with, and people are more relaxed around dealing with drug users”

Four of the five social workers on the CDS team had previous experience of working with drug users in drug treatment agencies. The depth of experiences varied, ranging from college placements to two years of post-qualification work experience. Given that all had chosen these positions it is clear that they came to their new posts with evident interest in drugs issues and in working with drug users. It was the view of most of these workers, however, that they came to their new post with insufficient training in drugs issues at basic training level.

One social worker reported that she viewed generic social work training as insufficient preparation for her current position with the specialist service as “only a minute part of the course in college was spent on drug use”. She saw the need for greater input at that level on drug issues with a child protection emphasis. This view was supported by at least one other social worker interviewed.

Overall it appeared that, while motivation to work with drug users was viewed as the primary qualification for working within the specialist service, knowledge and experience of working with drug users was viewed as highly desirable.

b. Management

At management level the view was expressed that it is important to have experience of working in the drugs area together with having an interest in addiction and wanting to specialise, but that it was difficult to find people with both.

c. Mainstream Team

Workers on the mainstream team appeared to view members of the CDS team as having specialist knowledge and training on drug issues. One worker, for example, believed that a key difference was in relation to knowledge of drugs services held by the CDS team-Mainstream workers did not, however, refer to any difference in approaches to clients between the mainstream and CDS team.

One of the factors contributing to the view that specialist knowledge of drug issues was required for the CDS team was the process by which positions were advertised and workers were recruited for this service. A number of workers within Community Care Area 5 believed that the new posts had not been advertised internally and that the members of the CDS team were all recruited externally. This appears to have created the impression among some mainstream workers that management believed that insufficient expertise about drugs issues existed within the existing staff of the community care team. This in turn may have reinforced a perception among the mainstream team that they had no ownership of the new service, or expertise on drug issues.

d. Local Drugs Task Force

A member of the Local Drugs Task Force also addressed the issue of the difference in training and knowledge between the two teams. Her perception was that the CDS offered a better service to drug-using parents and their children, and that when families were involved with the main team they were not well managed, as the mainstream social workers did not understand addiction issues. She contrasted this to the CDS team, where she believed workers have knowledge and experience of addiction, can recognise relapse, and can see the impact on children of addictive behaviour and alert the community child care worker to that. She argued that specialist knowledge of drugs was required to adequately provide a service to these families.

e. Other Agencies

The view held by workers in agencies with which the CDS has regular contact, including hostels and drug treatment agencies, generally held the view that this specialist team has provided a better service to drug using clients due to their knowledge about addiction issues and the intensive nature of the work. The team members were viewed as being accessible and supportive. One worker expressed the view that the approach and knowledge of the CDS team has helped to counteract the negative image held by clients about social workers.

Ongoing Training and Information Needs

Two of the social workers emphasised that it was critical to the delivery of a good service that workers be encouraged to update their training and maintain current knowledge about drug issues. One worker believed it was appalling that the EHB was not doing more to “update their training needs.... the EHB should give something back to the team as individuals to keep them motivated in work.” Similarly, another worker said that it was necessary to have ongoing training and seminars on drug issues.

Summary

Whereas members of the CDS team viewed their differences mainly in terms of approach and motivation for working with drug users, it appeared that within the mainstream community care team the main difference was perceived to be in terms of the degree of knowledge held by the CDS team regarding services for drug users and in the allocation of smaller caseloads.

In relation to recruitment and training a lack of clarity and consensus regarding the focus of the service emerged. CDS team workers and mainstream workers saw the recruitment process as heavily oriented towards experience with drug-related issues, while the child protection role was viewed as having been downplayed. Current management personnel emphasised that, although the service has a dual focus, the core activity is child protection and support, implying that staff should be recruited who have experience and knowledge of both drugs issues and child protection, but whose key training and experience is in relation to child protection and support.

It is clear from these interviews that it is necessary to have a clear understanding of the training needs associated with delivering a service with a dual focus, but that staff members believed that this clarity has not yet been achieved.

There is a need for clarity about training and experience necessary for new staff coming into the service, for further training on addiction, especially in relation to parenting, at basic social work training level, and for all social workers to have the option of updating their training on opiate and tranquillizer addiction within the EHB

OPERATION OF THE SERVICE

This section outlines the roles and function of staff of the Community Drugs Service team. Information is based on interviews with staff and on participant observation.

Social Workers

Role and Activities

Social workers on this team perceived their role to involve taking chronic cases and supporting them to become stable. Social workers on this team interpret this role as directed at helping drug-using clients to become stable in terms of their drug use, and may involve helping them to start a methadone maintenance programme. Once stability has been achieved, the work is perceived as focusing on avoiding crises, accessing resources, support and help as well as therapeutic intervention. It involves issues of housing, child sexual abuse and neglect issues, and has a focus on parenting, especially in terms of the establishment of routines. Social workers on this team generally perceive their role as being different to that of social workers on the main community care team, in terms of a greater focus on drug issues and on parents.

Much of the work in connection with drug issues involves liaison with other agencies; contacting GPs, drug treatment centres, foster parents, hostels, the County Council, Dublin Corporation, and any other agencies families deal with. Social workers act as advocates for their clients, often seeing their role as raising awareness of drug issues and challenging negative stereotypes of their client group.

In terms of a direct service to children, the two sub-teams (Ballyfermot and Clondalkin) differ in this regard due to differences in staffing. Such services are not required of social workers to the same degree in Clondalkin, where there is a community child care worker, compared with Ballyfermot, where the position is vacant. The workers in Ballyfermot see themselves as attempting to “bridge the gap” in the absence of a community child care worker.

These social workers also see their role as involving carrying out the statutory duties of a social worker in relation to child protection. A number of those interviewed found that child protection was a larger component of their work than they had anticipated when they accepted their positions. This work involves ensuring that children are safe, through assessment of adequacy of care, and, where necessary, removal of children into care. As such, it is similar to the work of mainstream social workers in community care, but is facilitated by the high level of home visits that are a feature of the work of this team.

A further feature of their role is prevention, particularly in relation to drug use. Workers are involved in providing an information and advice service. Assessment may also be provided where appropriate. Workers on the Clondalkin team take part in a weekly “drop-in” service through the local community agency Cumas. Workers on the Ballyfermot team provide information and advice through an Advice Service based in the health centre once a week. This service does not involve casework but in situations of crisis involving child welfare or protection issues clients may be referred to the community care duty system.

Other activities for social workers on the team involve attending team meetings, arranging family support, liaison with foster parents’ social workers. A large component of the work is family visits and access visits. The frequency of such visits varies, but may occur up to three times per week per family. Priority is given to keeping a strong link between parents and children when children are in care and on reunification where appropriate. Ideally all placements are short-term. When children cannot live with their parents, the team goes to great lengths to place children within their extended families and to support that placement through regular contact with carers.

Team Leader

The team leader, as in other community care teams, provides induction and information to new members of the team. Referrals to the team are made to the team leader initially who then allocates those referrals. She provides supervision for workers, attends case conferences, and makes decisions about closing cases. Additional duties include liaison with the Task Forces and representing the views of the team at Steering Group meetings. The difference compared with leading a non-specialist team is in terms of the client group and the knowledge and experience required about drug issues.

Community Child Care Workers

One community child care worker is employed on this team, and is assigned to the Clondalkin area. There are two vacant posts, one for the Ballyfermot area, and one floating worker.

The role of the community child care worker is to provide therapeutic support to children and teenagers presenting to the service. The focus of the work is supporting children and developing trust, the children being engaged on a voluntary basis. The community child care worker strives to create for the children a safe place, where children are assured of confidentiality. None of the work is crisis intervention; much of it concentrates on children having an understanding and ability to cope with their home circumstances, whatever they are. All work is age appropriate and varies according to the children's individual needs, which are identified during the assessment period. Issues covered may include loss and separation, sense of self, sense of purpose, belonging, identity, exploring reasons for moves, reasons why people take drugs and behaviour modification.

The key difference in the work in comparison with the main team is in terms of the ratio of community child care workers to social workers. Whereas in the main team there are approximately three community child care workers to twenty social workers, in the Community Drugs Service there are three community child care worker positions to four social work positions. This means that there is greater direct support for children through this team, and suggests that the model in place for this team is one of co-working between community child care workers and social workers, rather than a model in which community child care workers provide an ancillary service to social workers.

The community child care worker in Clondalkin typically meets children on her caseload on a weekly basis. She collects children from school and brings them to her office where sessions are conducted. These are divided between work and play time. Work involves a range of writing and artistic activities, which mainly centre on helping children to explore their experiences with their families and while in care. The community child care worker uses worksheets to make life-story books. Each book is tailored to the unique circumstances and age of the child. The following example was observed in a session with a child.

Example:

The book observed contained drawings and writings concerning the moves the child had made with her family over her life, and included significant life events such as parental imprisonment. It also included a section on "feeling faces". These are drawings of faces expressing different emotions. The child was asked to name the feelings with a sentence and talk about her experience of such feelings. The child was also working with the community child care worker on self-control issues.

The community child care worker also works closely with parents and carers. This work involves regular contact to encourage the relationship with the child.

The community child care worker partakes in liaison with relevant voluntary and statutory agencies, including schools and community groups, youth projects and other services to children.

Following the focus group with the sub-team, the community child care worker emphasised that most of her work is carried out on a one-to-one basis, but work is also done with groups where children of the same age have similar problems. Where there are young children in families, she provides early intervention and can offer support and advice on child development. She also advocates on behalf of the child, particularly at reviews and case conferences, helping represent the child's perspective in such forums.

Fostering Social Workers

There are two fostering social workers, each of whom works a 7-hour day once a week with the CDS team. For the remaining time each has a half-time post on the main Area 5 community care team.

The role of the fostering social workers is to recruit, assess, and support families to provide care for children. The service provided through the CDS team differs from typical fostering services. It was envisaged at the start up of the service that a special fostering service would be set up in conjunction with the CDS to meet the needs of the client group, which would provide care for children while parents were becoming stable (for example, in residential treatment).

The fostering social workers conducted a consultation process with local community groups, drug treatment centres, community workers and the child care manager. The feedback from this process was that parents often have negative attitudes to their children coming into the care of the EHB and that a different approach was necessary. The Family Care Initiative was established as an alternative. The focus of Family Care is the provision of a flexible service to enable parents with drug dependency to attend treatment while their children are being cared for by approved Family Carers. This is based on a voluntary agreement between the parents, Family Carers, and the EHB. Family Care is a short-term service where the stated aim is that the child will return to the care of their parents. The service is a pilot project in Area 5 and is currently at the stage of recruitment and assessment of families. The workers would like this project to be evaluated.

Associated Services

Family Support Workers

The family support service is a team of local people employed by the EHB to provide practical and flexible support to families in caring for their children. The service has the overall objective of promoting the health, welfare and development of the child within the family and the nature of intervention is specific to the needs of the particular family. Intervention with families often includes tasks such as:

- ensuring that children attend school each morning
- attending appointments with parents
- establishing a routine in a home
- linking families with local community supports

The co-ordinator of the service is a social worker who is supervised by a team leader from the main social work team. In Community Care Area 5, 19 family support workers make up the team and are employed for their skills, life experience and commitment to the aims of the service. Training is provided through the co-ordinator. Referrals can come from anyone in

the area, and roughly 75% of referrals have drug or alcohol use as a feature of the referral. Referrals from the CDS make up only a small proportion of referrals to the service.

Experience and training about drug dependency and its impact on families varies among workers, although many have had an input from the community child care worker on the CDS who ran a workshop for the service. Some workers also attended a short course organised by a drugs education officer in the local library. The key factor in deciding whom to allocate to a family where drug dependency is indicated is interest in working with this client group.

Factors influencing the operation of the Service

Caseload

One of the main features differentiating the operation of this service from mainstream community care is the smaller caseload of social workers. Caseloads on this team range from 6 to 9 families, compared with 20 on the main team. The level of support to families is therefore substantially higher. Clients are parents who are drug users, and their children. In addition, this team has two teenage drug users on its caseload. Information about current cases is summarised in Table 2 below.

A number of workers raised the issue of closing cases as being a concern on this team. The team leader makes decisions about closure of cases. Workers perceive the need for greater clarity on the issue of when to close cases. These families differ from other clients in that there are frequently relapses associated with drug dependence. However, the role of crisis avoidance must be balanced with avoiding creating dependency on the service, in the views of some workers.

Table 2. Community Drugs Service Statistics (April 1999)

| | |
|------------------------------------------------------------------------|----|
| Cases | |
| Total No. of cases | 27 |
| No. of cases Clondalkin | 14 |
| No. of cases Ballyfermot | 13 |
| No. of cases where homelessness is an issue | 16 |
| Total no. of teenagers* | 2 |
| Total no. of children CDS is involved with (excluding teenagers above) | 47 |
| Breakdown of Care of Children | |
| At home | 27 |
| In care of extended family | 13 |
| In foster care (foster family not related to the child) | 5 |
| Residential care | 1 |
| Going through out-of-hours service | 1 |
| Case Closure | |
| No. closed since partnership with Task Forces (end May 1998) | 6 |
| No. of cases due for closure | 1 |
| No. of cases transferred** | 1 |
| No. of cases due for transfer | 4 |

* 1 each Clondalkin & Ballyfermot

** transfer indicates transferred to another health board area or from Community Drugs Service back to main community care team as drugs no longer an issue.

Practice Orientation

Another factor perceived by workers as strongly influencing the operation of the service is the experience and practice orientation of the workers. The team appears to share similar views on practice, which are based around a strengths perspective and a focus on positives. Three social workers on the CDS team raised this as an issue in individual interviews. At focus groups the issue was raised again, and team members stated that they saw their theoretical backgrounds as being important and that there was a need to make explicit what theories influenced the practice of the team particularly for this client group. It is not within the scope of this evaluation to comprehensively describe the theoretical backgrounds that influence workers' practice orientation. As stated above, the CDS team plans to document its theoretical perspectives in a forthcoming team review. In summary, the current orientation is based around:

- Motivational interviewing
- Strengths perspective
- Client-centred models
- Systems perspective

These allow workers to intervene in a therapeutic way. The theories informing workers practice contrast with the medical model of service provision, which tends to characterise the approach to a good deal of work with drug-users.

OUTCOMES FOR FAMILIES

Introduction

Seven clients were interviewed to obtain feedback about their expectations from the CDS and about the nature of outcomes of interventions by the CDS. Clients who had experience of the mainstream social work service were asked to talk about this. Clients were also asked about what supports they had and if they had been linked into any additional supports through their social worker. Their suggestions for improvements to the service were also requested. Three clients of the Child Care service were asked for their evaluation. Information from interviews is supplemented by observations.

PARENTS' PERCEPTION OF SERVICE²

Approach to Clients

All clients interviewed stated that they trusted their social worker and that they were always kept informed as to what the social worker was doing. One parent commented:

“She’s real straightforward, she wouldn’t do anything behind your back, she tells you what she’s doing.”

Outcomes were often practical as opposed to therapeutic and the way the service was delivered to clients, the way they were treated by workers, building confidence and self-esteem, listening, was of major importance to how parents saw the impact of the service on them. One parent described this as follows:

“She treats me like, just like a human person. Like a normal person who isn’t on drugs.”

Support

A striking feature of the feedback from parents was their perception that the social worker was there for them both as parents and as individuals, and not just to make sure their children were being cared for. Parents clearly identified the social worker as a support and resource to them.

“[Social worker] not only comes to see the baby, she comes to see you.”

“[Social worker] has time for you and wants to help you.”

Clients who had previous social workers expressed concern that those mainstream social workers appeared only interested in their children.

“They were just mainly concerned about the baby.”

“They were more interested in the kids, how they were doing”

These parents’ views that mainstream social workers predominantly focus on children especially when children go into care, was shared by some mainstream social workers interviewed. Some parents interviewed said that the social workers were also a support to their extended family and for one woman, a support to her partner. Support was considered a vital part of the service. One parent said

² None of the parents interviewed had children who were clients of the community child care worker. Some parents interviewed were from the Ballyfermot area and thus had no access to a community child care service on the CDS.

“[You] need to know they’re not there to judge you, they’ll help and support you.”

It appeared that parents were more satisfied with the nature and degree of support they received from the CDS than the mainstream service.

Accessibility and Availability

Most parents interviewed perceived that the CDS social worker was available and accessible. Clients of the service said they wanted to be able to ring and know that they would see their social worker today or tomorrow, that there was no point in coming three weeks after a crisis. The close proximity of the team offices to the local drugs clinics contributes to this ease of access to the CDS – the clinic is a three-minute walk from the offices, and many clients attend these clinics for drug treatment. Comments from parents about CDS social workers included:

“You can contact her anytime and she’s down to you and she sees you on a regular basis”

“She always says to me anytime you want, just drop over.”

Clients were divided equally on their opinions regarding accessibility of their previous social worker. Two clients described their mainstream social workers as very good, but for one client problems accessing her social worker made the service unsatisfactory.

“If I look for [social worker] today, I may not see her until Friday. I know it’s not her fault, as there’s so many looking for social workers.”

Accessibility and availability would seem to be the part of the service valued the most by service users. These features of the service were spoken about by all but one of the clients interviewed and half of those repeatedly referred to this aspect of the service. One client stated that she sees her CDS social worker about once every three to four weeks and described this as “probably the worst thing” about the service. Her previous CDS worker called every week and could be located in the nearby Health Centre. The client has no phone and lives roughly five miles from the team offices, which would be very difficult to access by means of public transport.

Advocacy and Liaison

Clients greatly valued the advocacy role the social worker in the service took on. One service user said that support from the CDS social worker had helped to prevent her threatened eviction by the County Council. The social worker accompanied this woman to all her meetings with the County Council concerning her imminent eviction and helped her to present her case. The social worker also advocated on client’s behalf to obtain crèche placements. On the other hand, one client articulated extreme dissatisfaction that her social worker was unable to prevent her eviction and the subsequent separation of her family by the section of the EHB providing services to the homeless. Social workers were also perceived as having accessed services for clients that they previously had not known of or had not availed of. Such services would include drug treatment services of varying kinds, counselling and support for children, family support services, and accommodation.

Relationships with Children

One striking feature of interviews and observations was the extent to which carers and parents describe the children as being attached to their social worker. On two occasions, carers said that the children were very attached to their social worker. In addition, two parents also made a point of talking about how much their children liked seeing the family’s social worker. This may be another reflection of the positive relationships between CDS social workers and their clients.

Family Support Service

When asked about supports in their lives parents who had family support workers identified them as one of the supports they wished to continue with. The nature of the help provided by the family support worker varied between clients. One client said that she helps her clean and makes sure she attends her maintenance program. Another client who is caring for her grandchildren described her family support worker as 'great' and 'ordinary' and said the worker listened to her and how she felt about having three children on drugs. The client's **son** also found this woman to be a resource. A third woman described how her family had a family support worker available to them on a daily basis for six months, as she was not coping well with her children. As well as minding the children while the mother attended a drug clinic, the family support worker was also identified by the mother as a support for her. In general, clients viewed the work of the family support workers in a positive light and valued the service.

Suggested Adaptations

Clients were asked for their opinions as to how the service could be improved. Some were also asked about whether the service should continue as it is or be mainstreamed. All those that responded concerning mainstreaming said that the service should continue as it is, that the social worker would not be able to do their job as well if on the main team. One client suggested that the team should employ counsellors who were drug addicts, as she felt that those who have personal experience of drug use have a better understanding of drug-related issues.

Children's Perceptions Of The Child Care Service

Three children were interviewed as part of the evaluation process. These interviews focused largely on the nature of the activities in which children were involved when meeting the community child care worker, and their views of how the service helped or supported them. Details about the nature of the service to children are reported under "Operation of the Service" above.

All the children said that they liked talking to the community child care worker and clearly understood the expectations of the work. A trusting relationship built up over time, individual attention, and confidentiality were the main issues raised by the children.

One child felt that it was valuable to be able to talk to the community child care worker about her experiences, and feel sure that the community child care worker would not pass on any of that information. It was important to the child, who was in the care of her aunt, to be able to talk to somebody in confidence outside the family about her experiences in their care. She also found it important to be able to discuss her relationship and past experiences with her natural family, and it appeared that talking to the community child care worker gave her a sense of connection to them. She said "...sometimes [community child care worker] reminds me of things that I'd forget about'..."

The second child, who was living with one of his parents and some of his siblings, viewed the community child care worker as a source of support in dealing with his peers, who taunted him about the absence of his other parent. He also spent time talking with the community child care worker about his own behaviour at school and with his peers, and said that he found it helpful to do so. He said that he would sometimes take the community child care worker's advice about "dealing with slugging and fighting in school".

The third child, who was also in the care of a relative, emphasised the importance to her of the confidentiality assured in her conversation with the community child care worker, and the individual attention she received from her. She valued receiving support and encouragement to maintain contact with her mother and to work on their relationship. She also attributed her current foster care arrangement with a member of her extended family to the community child care worker, and was happier in this placement than she had been previously.

All three children talked about personally liking the community child care worker and her approach to them a great deal. One child pointed out that an important factor in this was the duration and frequency of her contact with the community child care worker. The stability this offered had allowed her to build a trusting relationship with the community child care worker.

Outside Agencies Perceptions of Outcomes

Adult Outcomes

A worker from a local drug agency said that clients now view social workers as positive and ask for liaison. She stated that parents have been linked into training and have got help with accommodation and evictions. Outcomes were described as “brilliant.” The CDS workers were said to have “a huge focus on what is possible.”

Child Outcomes

Benefits for children were thought to include having a routine put back in their day and getting to school. The CDS were also described as listening to the children. Hostel workers described the service as “brilliant”, one of the main benefits for clients being the face-to-face contact from their social worker as opposed to a weekly phone call. The team’s capacity to make a quick response to their client’s or the hostel’s concerns was identified as making an enormous difference.

Summary

Perceptions of outcomes were generally extremely positive. Clients of the service highly valued the approach and accessibility of the service providers and felt that they were benefiting from it. Children valued the stability, confidentiality and support for family relationships, and the approach of the community child care worker.

CONCLUSIONS

The focus of this evaluation was to examine the implications of delivering the service as a specialist service or as part of the mainstream team. Outcomes for families were also to be explored.

The implications for the Community Drugs Team itself are as follows:

- The team needs to define its current aims and objectives, and to review its own progress to date.
- Families the CDS work with differ from other clients in that there are frequent relapses as a feature of drug dependency. The team needs to explore and decide on how to close cases of this nature. It is also important to note that the team works with some parents whose drug-use is stable but whose parenting is not perceived as needing further support.
- There is a need for clarity about training and experience necessary for new staff coming in to the service.
- The team also needs to clarify and state at the level of documented aims, what the ethos of the team is.

The implications for management:

- Need to decide clearly on the focus of the service, and to state this clearly in documentation.
- The service is currently provided in partnership with the Local Drugs Task Forces and has given rise to confusion as to who is to be held accountable for the service.
- Management, in consultation with the team, need to define what the CDS mean by preventative work, and especially to define the goals of prevention.
- The concept of partnership needs to be explored, as part of deciding what the nature of partnership, if any, between the EHB and the LDTFs will be, once funding ceases. There exists a consensus that Task Forces should not continue to fund the service, and that this should now be the responsibility of the EHB, if they wish the service to continue as it exists.

The implications for the mainstream team:

- Resources of information and advice on parents with a chronic opiate problem available from the CDS.
- There are an additional four social workers and one community child care worker to take on work that would normally have been taken on by the mainstream team.
- The mainstream team has less work with chronic opiate users than previously.

The implications for clients:

- Clients receive an intensive service with regular access to service providers
- Clients receive a child welfare and family support service from social workers and community child care workers who are knowledgeable about and have experience dealing with drug dependency issues.
- Both parents and children get a service as joint priorities.

The implications for partnership:

- Partnership with local groups leads to increased acceptance of EHB services at local level, and greater sense of ownership.
- Conditions of partnership need to be clarified in relation to funding.

Further conclusions:

- Need for further training on addiction, especially in relation to parenting, at basic social work training level.
- Need for all workers to have the option of updating their training on opiate and tranquillizer addiction within the EHB.
- Need for greater clarity about the relationship of the CDS to the main team. If it is seen as desirable that the specialist team is a sub-team of, or closely linked to the main team, then they need to have the opportunity to make a greater input into its design.
- The workers' perception is that the direction of the service was driven largely by the head social worker who set up the service. If the service is to continue to be jointly funded under the present partnership arrangement, there needs to be clarity at the outset regarding goals and the focus of management

Summary

In summary, the Community Drugs Service in Community Care Area 5 provides an intensive and specialist service to families. It is widely viewed as leading to positive outcomes for children and parents. The service is valued by clients, by workers within the EHB, by the Local Drugs Task Forces with whom it has shared partnership, and by other external agencies with whom it liaises. The future successful operation of the service will benefit from gaining clarity about its objectives, focus, training needs and ethos, and its relationship to the mainstream community care team. If the service is to continue to operate on the basis of partnership with community groups, clarity must be achieved about the respective roles and responsibilities of the partners. Key terms such as "prevention", "stability", and other terms that may have different connotations for the partner agencies, must be defined. Finally, the importance of explicitly recording and documenting expectations and decisions in relation to the service must be recognised.

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