REHABILITATION RESEARCH REPORT

Towards a blueprint for rehabilitation for opiate addicts in the Eastern Health Board area

Based on research carried out by Peter Dorman and Lynsey Jones.

Compiled by Peter Dorman.

July 1999.

Introduction.

These report papers were commissioned by the Drugs Rehabilitation Committee within the Eastern Health Board which has been meeting since May 1999. The reports are part of a research process being undertaken by the committee to better inform the planning of rehabilitation services for the future. This piece of research was carried out in June and July of 1999 by two contracted researchers, Peter Dorman and Lynsey Jones.

The package contains three reports.

1. *The clients' perspective.* This report is produced from 94 interviews with opiate addicts who are clients in services funded and/or operated by the Health Board. The report seeks to express the views of clients on rehabilitation and to illustrate their history and current life circumstances.

2. *The staffs' perspective.* This report is compiled having heard the views of health board staff, who work in the drugs service, on rehabilitation. A focus group was convened by the researchers in each of the three Health Board areas.

3. *The community groups' perspective.* A focus group was held to hear the views of those tackling the drugs issue in Task Forces, local area projects or community organisations. This third report is written in the light of that meeting.

While each of these reports stands in its own right, the package includes a summary which draws the conclusions of all three together. There are also appendices giving some information on the researchers and offering some reflections on the research process used which should be read in conjunction with all three reports.

The researchers are grateful to all the staff at the clinics, projects and rehabilitation centres that we visited, without whom this work could not have been possible. We also wish to thank all the clients who so generously gave of their time to help in the research.

Peter Dorman, July 1999

Report 1.

THE CLIENTS' PERSPECTIVE.

A profile of clients within the drugs service of the Eastern Health Board and their views on rehabilitation.

Based on research carried out by Peter Dorman and Lynsey Jones.
Compiled by Peter Dorman.
July 1999.

Report 1.

The Clients' Perspective.

Contents.

The Clients' Perspective.

Introduction and methodology.

This report was compiled on the basis of research carried out among 94 clients of the Eastern Health Board's drug service. Each client was interviewed alone for about twenty minutes, following a standard set of questions. The questions used are listed in appendix 1. The interviews had two main aims.

1. To build a profile of the client group at the moment both in terms of their background and current circumstances. This profile seeks to be comprehensive, covering accommodation, education, forensic history, social life and health, employment, drug use and history as well as family circumstances.

2. To ascertain the views of the client group on rehabilitation; what it would mean to them and how they believe it ought to be approached.

The majority of interviewees were attending clinics. Some were also in aftercare and rehab projects and some in residential settings. Clients were selected randomly, though the researchers attempted to strike a gender balance in the sample. An attempt was made in approaching the research to balance the desirability for qualitative as well as quantitative data. Consistency was ensured by a tight schedule of questions, but data was categorised after interviews were completed rather than fitted into pre-designed categories, in order not to restrict responses unduly. Further reflections on the scope and limitations of this research are to be found in appendix B of the reports package.

Tables 1 and 2 show the profile of our sample.

Location	Number Males	Number Females	Totals	Status
Anna Livia	2	1	3	methadone
Ashling	5	4	9	methadone
Domville House, Ballymun	5	4	9	methadone
Castle Street	5	5	10	methadone
City Clinic	6	3	9	methadone
Cuan Daire	1	5	6	methadone + 1 drug free
Patrick's St. D'Laoire	6	4	10	methadone
Kilbarrack	4	4	8	methadone
Kilbarrack Aftercare	3	1	4	methadone +1 drug free
Millbrook	8	3	11	methadone
Soilse	3	2	5	drug free
St Aengus Tallaght	6	4	10	methadone
	54	**40**	**94**	

Table 1. Profile of clients interviewed; gender, location and status re-opiates.

Age Category	Number of Clients
16 – 20	18
21 – 25	30
26 – 30	28
31 – 35	10
36 – 40	8

Table 2; Age Profile of clients interviewed

Section 1. Background and current circumstances of clients.

1a. Accommodation.

57.4% of those surveyed are unhappy with their accommodation. Within this group, there are three main reasons given for this.

1. *The building itself.* (20.3%) Interviewees complained of properties not being well maintained, being damp or cold and being too small for their needs. (70.2% of sample live in local authority accommodation. A further 8.5% live in accommodation rented from private landlords.)

2. *The locality.* (31.4%) Most mentioned the availability of drugs, problems with neighbours, feeling stigmatised and isolated and living in an area with poor facilities. Problems with evictions or threatened evictions are significant (see table 3).

3. *Tensions within the household* (48.1%) Mostly this referred to difficulties with relations, feeling a need for one's own space, and drugs within the home. 13 of the sample have been threatened with eviction by family and 5 were actually put out by a family member (see table 3).

The majority of the entire sample, 55.3%, live in their family home or in the family home of their partner. Of these. 56% find that accommodation unsuitable, mostly due to tensions within the household and overcrowding. This is especially true of those who live in the family home with children and/or a partner (13.8% of total sample). Almost all of these find living in their present accommodation very unsuitable.

Only 5 in the entire sample (5.3%) are single parents living alone with their child for children. Of these 5, only 1 was happy in her accommodation. Only 1 was male. Though interviewees were not specifically asked, it was clear that many sub-let their rented accommodation to their partners if they do not live with a family member.

22 (23.4%) are in a nuclear family unit, living in their accommodation with a partner and/or children. For 12 of the 22, accommodation is unsatisfactory, but

this is entirely to do with the building or the local area. None of this group reported tensions within the household as a problem. (17 of these households include children.) None of the entire sample is married, though one is divorced and another is engaged.

Finally, only 12 live alone and 5 of these are homeless. 7 of the entire sample were homeless. While only 7 are homeless in the sense that they are in bed and breakfast or hostel accommodation, it is clear that many others are in overcrowded housing with family members and are desperate for their own space.

Conclusions and implications for Rehabilitation

Most of the sample live in close contact with family in the family home. If not, they are typically living with a partner and/or children in their own accommodation. Few live alone. Rehabilitation that considers clients in isolation is not accounting for the reality. While 72.3% of the sample describe their family as supportive, it is also true that many find it difficult living in the family home. Any rehabilitation needs to consider the family context in which most addicts, recovering or using, are living.

	Local Authority	Family	Community
Threatened eviction	9	13	12
Actual eviction	7	5	4

Table 3; Evictions and threatened evictions.

1b. Family situation.

Given the close quarters which most clients occupy with partners or family members it is important to consider the nature of these relationships and the part drugs and alcohol play in them. On the positive side, 72.3% describe their family as supportive. Sometimes this refers to one figure in the family more than the others, mostly the mother. In many cases, addicts feel very guilty about the trouble they have brought on their households.

However, trouble has also been visited on them from within households. Some 26% have an alcoholic father. In 71% of these cases, the interviewee is male. In 50% of the total sample, a sibling or siblings are, or recently have been, heroin addicts.

While no specific question was asked relating to abuse, sexual or physical, it is worth noting that 9% of the total sample volunteered the information that they had been abused as a child.

In relation to partners, 65% of those interviewed regarded themselves as being in a stable relationship. The overwhelming majority of these were described as good to excellent (84% of those in relationship). Only 15% described it as “fair”. Only 1% regarded their relationship as poor to very poor.

This is significant given that key factors for rehabilitation mentioned by clients include a supportive partner and a supportive family. 15% of the sample specifically mentioned this as essential to their hope of recovery.

However, notwithstanding their good feeling about their relationships, are clients still in bad company as regards drug abuse? Of the sample, most clients’ partners are on clinics receiving methadone, (38% of those in relationship) just as they are. Only 11% of partners are using to any significant degree. 20% are now clean of all drugs including methadone. The remaining 31% of partners are not drug users at all.

Interestingly, though probably not significantly, the 2 whose relationship is rocky are with non-users. To balance this, of those interviewees who are drug free and in relationship, all were with a drug-clean or non-drug using partner.

Conclusions for Rehabilitation

Many attributed the success of their present relationships to two factors. Firstly, the fact that they are now drug-free or stable on methadone. This has improved immensely the quality of relationships with family and partners. Secondly, for many the fact that partners are going through the same problem has become a help to them. Support is best when accompanied by understanding. Notwithstanding the fact that 28% got into opiates through family or a partner, the route out of opiates for many may be the same.

Rehabilitation needs to take into account the reality of the relationships that clients are in. There may well be an opportunity to play to the strengths of the client's situation by considering partners together rather than only in isolation. Involving supportive family members may also be building on strengths already present in the client's life.

1c. Education.

60.6% of the sample did not have a positive experience of school. 46.8% never did any examinations while in school. Only 7 out of 94 did a leaving certificate. Females were happier with school; yet still 55% of them said it was fair to very poor. 65% of males were of that view. It is interesting to note in the table below that females do consistently better at taking exams than males. Within the entire sample only three who attempted examinations failed them.

Reflections on school can be divided into three categories. There are those who enjoyed school and remember it fondly. There are those who didn't and attribute blame to themselves for messing up a good opportunity or just not being interested. And there are those who feel that school failed them. They feel they were victimised by teachers and found the authoritarian regime hard to stomach. The research did not reveal any close correlation between being happy at school and staying on later in school. 5 of the 7 who did a leaving certificate were not very satisfied with school. However, 69% of those who found school good to excellent at least did some examination while they were there, whereas only 42% of those who found it poor to very poor did an examination.

Literacy.

It was not possible to do a conclusive assessment of literacy levels with interviewees. Clients were asked to evaluate their own literacy on a scale of 1 to 10. 22.5% of females scored themselves as 5 or less, while 24% of males recorded this score.

	Group	Inter	Junior	Leaving	None
Male	7%	20%	15%	4%	50%
Female	7.5%	22.5%	20%	7.5%	42.5%

Table 4; Examinations taken at school; % of total within gender group.

Post schooling education.

Following school, most of those sampled have some experience of further education, though only 2 went to college. Just fewer than 60% attended some form of course or training after school. The impression given was that these courses were more positively received than school, though an assessment of this was not solicited. It should be noted that while only 30% of males and 35% of females did not take any courses or training since school, 50% of males and 42.5% of females did not take examinations at school.

	FAS	Youth reach	computers	Community based	trade	college	None
Male	22%	6%	0%	4%	31%	2%	35%
Female	45%	5%	5%	7.5%	5%	2.5%	30%

Table 5; Post schooling courses; %s of total in gender group.

Many more females than males opted for Fás courses. Mostly these were general lifeskills courses incorporating some vocational training and personal development. Males opted mostly for specific trades, serving their time as glaziers, tilers, chefs etc. The small number of females in this group mostly apprenticed as hairdressers.

Courses desired

% total	Response	Total Number	No. Female	No. Male
35%	No interest	33	11	22
23%	Vocational	22	7	12
11%	Computers	11	3	8
11%	Anything	11	7	4
9%	Drugs	8	5	3
6%	Literacy	6	4	1
5%	Misc.	3	3	4

Table 6: Courses desired by clients.

Of the 35% who have no interest in courses, 22 were male and 11 female. Many of the males felt they didn't need further training as they already had a trade.

Most interest was in such vocational type training as forklift driving, painting and decorating, fitness instruction or HGV driving. It would appear that getting a job and having an income is the main purpose of training.

It should also be noted that a small but significant group is interested in training as drug counsellors or in drug prevention. They feel that they could use the experience they have had to assist others. This theme repeats throughout the research in the desire of some clients to get work in this area and the view held by many that there is a special place within the service for people who have experienced the problem themselves.

Many of the interviewees who were positive toward courses were desperate for some occupation during the day. Later we will see how, in their view, "having something to do" is key to rehabilitation.

Conclusions for rehabilitation

School has not suited a large section of the sample. Many experienced it as irrelevant, unable to address the difficulties of, for example, living in a chaotic household, and damaging to self-confidence. However, it should be noted that where they attempted examinations, almost all were successful, even if they were not particularly motivated or content with school. This. would indicate a capacity for achievement among the clients which presents hope for successful rehabilitation programmes that are non-authoritarian, respectful of individuals and which take account of the reality of their lives. The impression given by interviewees is that courses and training should relate to the securing of employment, and to rehabilitation, and give clients something meaningful to occupy the long days.

1 d. Social life and skills.

Indicators emerging so far about the importance of including supportive relationships, family supports, and a meaningful use of time in rehabilitation are thrown into sharp relief when the social profile of clients is examined.

49% of the sample say they have no friends at all outside of family or partners. Many commented that they don't trust anybody anymore.

86% have lost important friendships over drugs.

14% were totally unable, even when given encouragement, to name one skill, talent or quality they have.

Those who do have friends now choose them carefully. Most, 63% of those with friends, have friends who are clean or who have never used. 27% are friends with someone stable on methadone, as they are. Only 10% include among their friends a current drug user.

Many spoke at length about the efforts they go to, to isolate themselves from former "drug friends".

Table 7 overleaf shows that most of the sample think of their skills, talents and qualities in terms of their work (usually past work). Given that just less than 60% of them are unemployed, this is very significant. It is truer for males than females. Also males, much more so than females, did not mention any personal qualities such as being good with people, being warm hearted, or generous.

It is interesting to note, in terms of designing rehabilitation programmes, the relatively high number who see themselves as artistic and literary.

	Total number	% of sample	Females number	% of females	Males number	% of males
Vocational	46	49	13	32	33	61
Personal	18	19	13	33	5	9
Communications	10	11	6	15	4	7
Sports	15	16	5	13	10	19
Arts	29	31	14	35	15	28
None	13	14	4	10	9	17

Table 7; skills, talents and qualities identified by clients.

(note; clients entered themselves in more than one category. Thus % figures do not total 100)

1e. Employment.

As mentioned above 58.5% of the clients interviewed are unemployed. Further, of those working, 51% are on courses, mostly Community Employment schemes. Only less than half of those who are working work in the open market, and only 28% are semi-skilled or skilled workers. Most of these (30%) were in Tallaght, where we interviewed in evening clinics.

Having work or occupation was seen by those in work as crucial to their recovery. There were many stories of individuals who lapsed into instability through losing a job and conversely, of others whose recovery was greatly boosted by finding work. Indeed, when asked to identify what would be the biggest help to addicts, the second most popular response was “having something to do” at 38.2% of the sample.

Of course, it works both ways. Drug abuse itself destroys the possibility of work. 55% have had their working life seriously disrupted by their drug habit.

56% were not seeking work actively at the moment. This is a high figure given how important clients feel having work is. As table 8 shows, only 14% do not have an ambition to work and over 74% have a specific idea of what they would like to do. So why are clients not actively pursuing their ambitions?

Clients spoke of an array of factors that prevent them from entering the workforce. These include needing to be more stable, and needing to get completely clean. But the main reason that was mentioned, by over 25% of the sample, was a lack of training. People did not feel adequately equipped to even go after the work they would like.

Another key barrier to work identified was the fact that clients must attend at clinics each day. They feel it would be impossible to take up work and attend a clinic as well. 10.5% saw this as a main barrier to getting into work. Indeed, one client on a low methadone maintenance reported being discouraged by his doctor from taking up a job offer in the public service.

Clients were asked if they had ever received career guidance to assist them in getting into the work that they would want. Only 29% have actually had any form of career guidance. 71 % of these found it useful. All of those who had had career guidance but had not found it useful, had received it in school or at the social welfare office. The main context for useful career guidance was in rehabilitation programmes, aftercare, community based training or in the clinics. These would be situations where the person's drug problem was understood and guidance was given in the context of rehabilitation.

Perhaps unsurprisingly, table 8 shows that most males are aiming for vocational work, involving a trade such as glazing, sheet metal-working, catering etc. Females by and large do not opt for this. However, it is interesting to note that the highest preference among females is for work in drug education, addiction counselling or working with children of addicts. 22.5% of females expressed this preference.

	Total number	% of total sample (rounded off)	Female totals	% of female totals	Male totals	% of male totals
Vocational	20	21	2	5	18	33
Drugs	13	14	9	22.5	4	7
Nothing	13	14	7	17.5	6	11
Computers	11	12	6	15	5	9
Anything	9	9.5	3	7.5	7	13
Profession or business ownership	7	7.5	2	5	5	9
Professional Driver	5	5	0	0	2	9
Childcare	4	4	4	10	0	0
Sports/fitness	4	4	3	7.5	1	2
Shopwork	3	3	3	7.5	0	0
Work with animals	2	2	0	0	2	4
Languages	1	1	1	2.5	0	0

Table 8; Ambitions for work

Conclusions for rehabilitation.

Again, work and occupation must be an integral part of rehabilitation. While stabilisation is an important factor in achieving work, it is not the only one. Relevant training, made to measure career guidance and a stabilisation process that encourages and accommodates occupation rather than making it difficult, all need to be included.

1e. Forensic history.

85% of the sample have had trouble with the law.

Description Of crime	Total Number	% of total	Female total	% of females	Male total	% of males
Theft	47	50	22	55	25	46
No Crime	14	15	7	17.5	5	9
Violent crime	9	9.5	2	5	7	13
Vehicle and theft.	8	8.5	2	5	6	11
Possession	7	7	5	12.5	3	5.5
Vehicle	5	5	1	2.5	4	7.4
Theft and possession	4	4	1	2.5	3	5.5

Table 9. Criminal activity of clients.

As the table shows, the vast majority of crime is theft. Invariably this is to support the drug habit. Less than 13% of the sample attributed their crimes to factors other than drugs and few of these crimes involved theft.

All the non-opiate attributed crime was by males. Thus all female crime was opiate attributed.

In fact, 6 of the 12 who said their crimes were not opiate related were in trouble for. violent crimes such as murder, manslaughter and assault. Non-opiate related crimes then, account for two thirds of the violent crimes reported. It is important to note that while 50% of non-opiate attributed crimes (attributed to drink, anger about abuse etc.) were violent, less than 16% of opiate attributed crimes were violent. This is not to suggest that the crimes were not serious and did not involve significant trauma to victims.

Only 5% of the sample, all of whom are now in the service, either on methadone or drug free, admit to current crime. All of these were theft to supplement social welfare. Even allowing for some economy with the truth here, it appears clear that those in the sample have dramatically reduced their criminal activity through coming into the service.

Prison

44% of the sample have spent time in prison. This excludes periods in custody. 61% of males went to prison and 20% of females.

Clients were asked if they had any help with their drugs problem while in prison. Table 10 charts their responses.

Help	Total	% of those in prison (rounded off)	Total Females	% of females in prison	Total Males	% of females in prison
Detox	21	55	8	100	13	39
No help	12	29	0	0	12	36
Courses on addiction	2	5	0	0	2	6
Not on drugs while inside.	6	15	0	0	6	18

Table 10. Help offered in prison.

It is important to note that while 55% of those who went to prison had a detox, 57% of these did not find it of any use. They complained that it was too quick, too inflexible and that they went through awful sickness as a result. The two who did a drug addiction education course found it very valuable. Some of those who had no help did ask for it, but because they had clean urine on admission, they were refused help right through the sentence.

Almost 26% of those who were in prison, and who had a drug problem while there, actually managed to become drug fee during their time there. All however returned to drug use upon release, all but one through returning to their old drug-ridden environment. That one was homeless on release and returned to drugs to cope.

Conclusions for rehabilitation.

Methadone certainly appears to reduce crime significantly, which is welcome not only to society as a whole, but to the addicts, who are relieved of a daily pressure to find money for drugs. This is one reason for retaining methadone as part of a rehabilitation programme.

Given the profile of criminal activity of the sample and how low violent crime features in that, the question arises of how well that is understood by the general public. Rehabilitation will be much more successful in an environment where the general public has a balanced picture of addicts and how dangerous they are.

The opportunity that prison might afford for rehabilitation of addicts appears to be missed. Help is limited, inflexible or even non-existent and if an addict does manage to get clean, they do not appear to be supported in this upon release.

1f Health and well-being

Over 58% of the sample felt that their health is not as good as it should be. Many complain of sleeplessness, tiredness, pains in their joints, a lack of motivation, weight loss and poor dental health.

50% experienced frequent bouts of depression in the last month, which led to their not being able to function. 31% considered suicide, and 5% actually made plans to kill themselves in the month previous to the interview. One young man actually did overdose and was revived after being pronounced dead on arrival at hospital.

44% are prescribed sleeping tablets and/or anti-depressants. 55% of these also buy extra on the street. 32% did so more than 7 days out of the month previous to interview.

54% have hepatitis C, though many do not find it interferes with their functioning. 4% have tested HIV positive.

As for exercise, 45% engage only in walking. They talked of walking constantly. 23% take no exercise at all, while 32% engage in some sports, many as part of aftercare or a rehabilitation programme.

80% of females do not eat a hot meal regularly. This compares to 26% of males.

These stark figures speak for themselves. Any rehabilitation effort must take account of the deep personal unhappiness experienced by many of these people, as evidenced by the amount of tablet taking, depression and unhealthy lifestyles.

1.g. Drug history.

Many of the sample started illegal drug use at a young age. 41% began taking drugs illegally, including alcohol on a regular basis under the age of 14. One young man started on cannabis at the age of 6. 66% of those taking drugs under the age of 14 took substances other than alcohol or as well as alcohol. These were mostly cannabis, with some taking solvents and a few taking amphetamines.

Very few took opiates as a first drug; only 2 out of the 94 sampled. One of these took it in her late twenties for medical reasons. 61% took opiates for the first time in their teens. The most common age was 16. 35% started in their twenties.

The vast majority attributed their opiate abuse to peer pressure. For 28% this pressure came from friends. Many spoke of feeling they had to take heroin in order to be accepted. Family members, mostly siblings, influenced 16%. Partners introduced 12% to the drug. This mostly happened with the over twenties.

A significant number explained that they first took opiates to come down from designer drugs in the rave scene. Almost 10% said this was their reason. 14% turned to the widely available drug when struck by a crisis such as bereavement, the loss of a child, or coping with sexual abuse.

These percentages indicate the main reason given in interview. In reality, the motivation was almost always a combination of a few reasons. Many spoke of despising the drug for years, seeing their brothers and sisters suffer from it, but turning to it themselves in a time of crisis or in depression or boredom. Some also referred to aspects of their own personality as key factors, such as an “addictive personality”.

Main reason for opiate use	% of total (rounded off)
Peer pressure	28
Drugs in the family	16
Life crisis	14
Partner introducing the	12
Come-down from amphetamines	9.5
Boredom	8
Personality traits	6
Curiosity	3
Medical reasons	1

Table 11; Reasons for getting into opiate use.

Past periods of being drug free

As the purpose of this research is to identify clues to rehabilitation, and given that 86% want to be drug free as part or all of their rehabilitation, we asked clients if they had ever managed to be drug free in the past. Table 11 illustrates this.

Two thirds of the sample have experienced periods of being drug free since they first started taking opiates. Only 13% of those who were drug free sustained it beyond a year.

It is interesting to note that whereas most of those who achieved a drug free life for up to 4 months did so by detoxing themselves within their own environment, nobody who sustained it beyond 4 months did so by this means alone. Either removal from the environment and/or some significant new factor in life such as pregnancy, finding work or falling in love led to success in the longer term.

For those who did stay free long term, three main reasons were given for lapses. The main reason was a return to the old environment. For others, their job or other occupation around which life had begun to revolve was lost. Others found that even though they were free from chemical abuse, the underlying problems were still there. They still had not dealt with the personal issues that had led to drug abuse in the first place. This observation is useful in considering rehabilitation. Rehabilitation is not only about achieving abstinence. In the case of some, once this is achieved, perhaps the rest will follow. But this cannot be taken for granted.

Key factor in abstinence.	% of those who were drug free for under 1 month.	% of those who were drug free 1 – 4 months	% of those who were drug free4-12 months	% of those who were drug free Over 12 months.
Self detox in usual environment.	44	17.6	0	0
Pregnancy and birth of new baby.	11.1	0	27.7	25
Prison	11.1	29.4	11.1	0
Shock, (death of close friend through drugs)	11.1	11.7	5.5	0
Rehabilitation programme.	5.5	11.7	5.5	12.5
New environment.	1-6.5	11.7	27.7	25
Finding work	0	17.6	22.2	12.5
Finding significant relationship.	0	0	0	12.5

Table 12. Analysis of factors contributing to being drug free.

Current drug use.

Clients were asked, to identify from a prepared list, illicit drugs and alcohol, which they had taken during the past 30 days, and the frequency. The findings were as follows;

Drug	Total taking often or very often (more than 7 days in the month)	% of sample. (note. As individuals may record more than one substance; total will exceed 100%)
Cannabis	36	38
Heroin	24	32
Alcohol	22	23
Benzodiazepines	16	17

Table 13; Alcohol and illicit drugs taken more than 7 days out of the last 30.

A compilation of the same data excluding those who were not attending methadone clinics was made, and the result was as follows;

Drug	Total taking often or very often (more than 7 days in the month)	% of sample. (note. As individuals may record more than one substance; total will exceed 100%)
Cannabis	35	42
Heroin	21	25
Alcohol	19	23
Benzodiazepines	14	15

Table 13A;, Alcohol and illicit drugs taken more than 7 days out of the last 30.

(Excluding interviewees not on a methadone-dispensing clinic.)

Clients were also asked about cocaine, methadone bought illicitly and anti-depressants such as Prothiaden and DF 118s. While these were used they were used infrequently. A few mentioned that cocaine is very dear. Methadone was mostly bought when a clinic was missed and sometimes to top up on

prescribed levels where the client disagreed with the doctor over suitable amounts.

It should be carefully noted that benzodiazepines appear to have been hard to come by at the time the sample was taken. Many said they would use a lot more if they could get them. Furthermore, 44% of the entire sample are being prescribed sleeping tablets and/or anti-depressants. Of these, 34% are also frequently buying more of these tablets on the street. Typical amounts taken are 5 or 6 Dalmanes and/or 15-20 valium.

Of the locations where interviews were carried out, the heroin use in Kilbarrack was inordinately high.

Conclusions for Rehabilitation.

It is important to note, as said above, that rehabilitation does not necessarily equal being drug free. However, it is a large part of it, at least for the 86% who see that as their goal. From the above data it appears that locking oneself away in the house, going through the sickness and avoiding all contact with drug friends cannot be sustained for more than a few months. Significant other factors need to come into play. In the experience of the sampled group, these factors are finding an occupation, change of environment, having access to rehabilitation programmes and having a significant other person in one's life, such as a partner or a new child.

On the chemical dimension alone, rehabilitation needs to take account not only of opiates, but also of other drugs being frequently taken alongside them. Particular note should be made of benzodiazepine abuse, particularly as these are being prescribed to a large number of clients legally.

Section 2. Reflections of clients on Rehabilitation and services.

2a. *Views on Methadone.*

The impact of methadone in reducing the need to find money, thus reducing the motivation for and incidence of criminal activity such as theft and possession of illegal drugs has already been noted. The quality of relationships with partners and family which stabilisation affords has also been referred to. It is not surprising then that a majority of the sample is positive about methadone as a response to opiate addiction. 88% said it was good for them.

However, a significant minority has serious questions about the methadone programme. While 54% gave unqualified approval, 34% qualified their support with important reservations. A further 12% were totally opposed to the programme, though most of them are clients of it.

The main objections to, or concerns about methadone were;

- Methadone is much harder to get off than heroin is. People are not told what they are getting into when going on a course. It's too easy to get caught up in deeper and deeper addiction through methadone. Indeed, more than a few clients remarked that the clinic was their life now and that they will never get off the drug. 46% of the entire sample have been on prescribed methadone for over a year and a half. Many have been on it for five to ten years.
- There was a lot of concern about abuse of the service. Clients observe other clients continuing to abuse heroin and to stay on clinics. They feel that urine testing is not rigorous enough. Furthermore, there was widespread concern about young people, who really don't need to be on methadone, coming into programmes to be in the "clinic crowd" and to get free or almost free drugs.

- Many clients felt that doctors are too complacent about using methadone. They find themselves having to fight to get their levels adjusted up or down. Their experience is that doctors do not have the time and sometimes not the interest to listen to the individual needs of a client. The image of feeling like cattle was used more than once.
- Being on a clinic can interfere with finding an occupation which is key to recovery. Some clients felt the attitude was to get them solidly stable before they can work. They felt that they needed an appropriate level of work or other occupation to achieve stability. Many clients who had the opportunity to work while in clinics, especially in the open market, felt they had to hide the fact that they were on a methadone course from their employer. The opening times of clinics do not always accommodate a working life.

These criticisms should not mask the fact that most clients feel that methadone, warts and all, is an important part of their rehabilitation process. But not methadone alone! Where clients feel methadone is all there is, there appears a deep sense of alienation from the state, and anger about being swept under the carpet. A few called it a form of social control and others dismiss it as just a money making racket for the medical people. “A life on methadone is good enough for you” is the message they receive.

2b. Views on the needs of addicts.

When asked to pinpoint precisely what is needed, clients responded as follows;

	Number	% of total sample.
Rehabilitation programmes. (e.g. aftercare, addiction education.)	43	45.7
Things to do.	36	38.2
More understanding attitude	27	28.2
More clinics	22	23.4
Residential detox	18	19.1
Counsellors	18	19.1
Peer support systems	12	12.7
Accommodation.	5	5.3

Table 14. What is needed most to help addicts.

There are a number of striking aspects to this data.

Firstly, taken all together, it represents a balance between different elements within an overall rehabilitation model. It does not say that the answer is to be found in one single service. Rather it represents a variety, within which an individual can find what they need. For example, it balances residential detox with local clinics, individual counselling with group peer support.

Secondly, it highlights the required attitude behind the services. Clients need to be listened to, to be understood. They want to be involved in shaping services, to have an input. They are looking for people who have been in their situation to be more involved in service delivery. As evidenced earlier, a significant number of them want to some day work in services themselves.

They seek this understanding not just from service deliverers, but also from the general public. They feel the burden of public stigma, and speak of feeling like lepers. They would like the wider public to understand what they are actually like, and what being an addict is actually like.

Thirdly, this response to the question of what addicts need does give an important place to methadone, but the highest need is for rehabilitation. Methadone needs to be seen, not as an end in itself, but as part of a strategy for rehabilitation.

Report 2.

“The Staff Perspective”

The views of Eastern Health Board Drugs Service Staff on Rehabilitation for opiate Addicts.

By Peter Dorman.
July 1999.

Report 2. The Staff Perspective.

Introduction and background.

This report was compiled following meeting of three focus groups of staff working in the Eastern Health Board drugs service. One meeting was held within each Health Board area. All levels of staff were represented, from local area managers to general assistants in clinics, to doctors, to counsellors, to outreach workers. A list of those who attended each meeting is contained in Appendix 1.

The meetings were held in the context of wider research into rehabilitation, its meaning and implications for the drugs service, involving clients and community groups as well as statutory staff.

As many of the same themes reoccurred during the meetings, the report sets out an overall picture of views expressed across the three events. Where significant differences were expressed at different meetings, these are noted.

This report should be read in the conjunction with the other two reports in this report package, "The Clients' Perspective" and "The Community Groups Perspective". This report is cross referenced with report 1, "The Clients' Perspective" by reference to relevant statistics from that report in italics under the theme headings below.

Methodology.

The focus groups met in Dun Laoghaire on 16th July. Phibsboro tower on 23rd July and in Cherry Orchard on 30th July. Each meeting lasted an hour and a half and was structured as follows;

1. Participants were welcomed and asked to introduce themselves.

2. The background and purpose of the meeting was explained.

3. Participants were asked to think of an individual client that they know well, and to write down what, in that person's particular case, rehabilitation would mean. They were then asked to share this in small groups and, in the light of that sharing to identify key elements in rehabilitation; what are we saying when we say that a person is moving towards rehabilitation?

4. Given these agreed key elements, the group was then invited to consider how the service as it stands presently is or is not a service of rehabilitation.

5. Finally, a discussion was invited about specific concrete changes that are required in order to create a service that is more of a service of rehabilitation.

Main themes emerging from the meetings.

Work and occupation.

Universally, there was agreement that work is key to rehabilitation. Specific points made in regard to this theme were;

The service needs to think about helping clients into "real jobs", which offer long term prospects and the opportunity for a decent wage. There was concern about too much reliance on Community Employment and Fás training. The Phibsboro meeting in particular was critical of Community Employment, saying that it was a dead-end for people. Clients were not being encouraged to develop a serious work ethic. "Five years in C.E. is a waste of time". It was also pointed out that women with children receive substantially more financial incentives to go on Fás schemes than men do. Many women are taking up Fás training simply for the money, and the training is not proving beneficial in terms of leading to regular employment.

Clients' Perspective: 58.5% of clients are unemployed. 49% of those working are in government sponsored schemes. 45% of females have been on Fás courses compared to 22% of males.

While helping clients achieve long term work was agreed as a priority, it was also recognised that this is an immensely difficult task for many clients. Clients would need individual career guidance, tailored to their individual needs. There would be a need in the case of many to provide bridging programmes, to build their self confidence, afford them appropriate training and generally ease them into the world of work.

Clients' Perspective. 78% of clients have specific ambitions to be in work. 38.2% recognise occupation as the most important element in recovery. Yet 56% are not actively seeking work. 25% said they would need training before they could pursue their ambitions.

There was a concern about setting clients up to fail, by rushing them into work too quickly. The tailored career development mentioned above was needed to offset this. Also, it was suggested that if clients were on short-term, interim work programmes, they should be meaningful and achievable, with concrete outcomes. The Millennium Project in Finglas was suggested as a model at the Cherry Orchard meeting.

There was a strong need to develop links with organisations such as Fás and 1BEC to facilitate the employment of clients. The service needs to work closely with employers to offset fears about taking recovered or stabilised drug addicts into their employment. Issues such as safety in the workplace, security from theft and reliability are legitimate concerns of employers in regard to this group. Such links could ensure that suitable clients could find employment.

Clients Perspective; 55 % of clients have had their working life seriously disrupted due to their drug taking, mostly through absenteeism and pilfering.

There was some debate within the meetings as to how sensitive the service is in relation to individual clients' readiness for work. It was put to the meetings that some clients find that having to attend clinics at set hours is preventing them from getting into occupation and so militating against their recovery. The Cherry Orchard meeting felt that this should not be a problem, that there was enough flexibility of hours and openness to negotiating "take-aways" with clients. The other meetings had mixed feelings about the issue. On the one hand clients had to be realistic about how stable they were, and many were not realistic. On the other hand, perhaps the service does not listen well enough to clients in regard to this problem, and should offer more flexibility.

Clients Perspective. 10.5% of clients felt that attendance at clinics was a serious barrier to finding work.

Integration of responses.

The need to develop more links with organisations such as IBEC and Fás to enhance employment prospects for clients has already been mentioned. But this is only one aspect of a much broader opinion that integration with a range of other services, and indeed within the Health Board service itself, was a key to moving forward. Rehabilitation cannot be developed by the drugs service alone. Given the reality that clients live in communities, in families, and have regular dealings with the law, the prisons, the social welfare services, and the local housing authorities, any comprehensive blueprint for rehabilitation must be worked out in partnership with all of these. This was a central theme in all of the meetings.

Integration with Fás, IBEC and other employment related groups has already been discussed above.

Integration between government departments, particularly Justice, Community Social and Family Affairs, and Environment, was seen as essential. It was noted at all three meetings, that while co-operation between statutory staff on

the ground was common across these three departments, the integration at policy level was sadly lacking. Integrated policies are now needed, and a change in the culture of "departmentalism" within the statutory sector is needed.

The example of required statutory integration that was most frequently elaborated upon was in the area of justice, particularly the prisons. It was lamented that the opportunity for rehabilitation which prison affords is being lost. This relates not only to the development of programmes within prisons but the link-up between any such programmes and services on the outside. Too many clients are returning from prison to the community with no support in any area of their lives, including drug abuse.

Clients Perspective. 44% of clients have been to prison. 60% of these had help with drugs in prison but of these, 57% did not find this help useful. 26% became drug free while in prison. 0% remained drug free after release.

Apart from integration between statutory services, the point was made at the Cherry Orchard meeting that there is a need for integration within the drugs service itself. Staff need to know what options already exist for clients within the service so pathways and progression routes can be availed of. Communication within the service could be improved.

A third aspect of integration identified was that between the service and the local communities. As well as the service developing rehabilitation projects of its own, such as Soilse, it could avail of local community resources in the clients' own areas. The Service could not only link more with existing community projects and place clients in them, it could also work with community groups to develop new services around the clients living locally.

Environment.

There was a recognition that clients who desire recovery are coping with a very difficult situation in their local environment. The availability of drugs

locally, and drug abuse within clients' own households make abstinence very hard. There was much debate about the attitude that should be taken to this problem. Are we getting anywhere while clients' communities remain communities of poverty? Is rehabilitation realistic in such circumstances? What is the place of residential rehabilitation where clients are able to remove themselves to recover? Do they not have to return home some time? Do we need to develop a strategy that allows people safely remain in their localities, with supports in place to facilitate recovery there?

If there was consensus on this within and across the meetings it was that there needed to be a range of options. There is a place for residentials, but they will have most impact where support systems of continued rehabilitation in the home community are in place. There is an urgent need for half-way houses to facilitate the return of recovering addicts back to their communities. Some frustration was expressed at the Phibsboro meeting that Health Board half-way houses have been called for for years and nothing was ever done.

Also in Phibsboro, a strong case was made for changing the environment. It was felt that the state should not settle for facilitating people to cope with unacceptable living conditions. While drug-specific rehabilitation services should be developed, this should be as well as, not instead of, changing the conditions in which people are forced to live and which lead to so much drug abuse in the first place.

Clients Perspective 37.2% achieved total drug-free life for up to 4 months while remaining in unchanged conditions with unchanged life circumstances. 0% achieved total drug-free life for more than 4 months in these circumstances. 8.5% did have episodes of drug-free life lasting more than 1 year. Of these 25% attributed their success to a new environment. All of these lapsed immediately after returning to their old environment.

Meeting basic needs.

The concern was expressed that rehabilitation might be reserved for the more able, better resourced and less chaotic clients. It needs to be for everyone, including those who are the most damaged, the most chaotic and living in the poorest conditions. One participant in Cherry Orchard used the image of rehabilitation as parenting. Some of the particular basic needs that were elaborated upon were;

Housing. Clients need adequate accommodation that is safe and secure as a basic step in any rehabilitation process.

Clients Perspective; 57.4% of clients were dissatisfied with their accommodation. 7.5% were in B&B or hostels. 36% had been threatened with eviction by family, local authority or vigilantes, and 17% had actually been evicted.

Childcare. Childcare needs to be part and parcel of any rehabilitation programmes.

Individuality.

There was a recognition across the board that rehabilitation does not mean the same thing to each client. All have a different story and different needs. Some particular categories of client were highlighted. These were; young people, those on waiting lists, those who are most chaotic, those who had no ambition to be drug free, gay men and women.

(Clients' Perspective; 80% of females do not eat a regular hot meal.)

There was debate in each focus group as to whether the meaning of rehabilitation for each client would be set by the clients or the service. Some spoke of rehabilitation as normalisation. Others questioned what normality is,

and who defines it. It was recognised that in many if not most cases, clients coming into the service have no capacity to make choices. This capacity to choose has to be created and then the client could take more and more of a role in setting his or her own targets. However, this process requires staff and clients to work closely together on the client's rehabilitation.

Specific points made in relation to the individuality of clients were;

Clients need individual comprehensive assessment on coming into the service. This assessment could develop into an evaluation of progress allowing the client to become more and more involved in developing their progression routes.

The notion of key-working was suggested, where a client would have a specific staff member who would journey with them in their rehabilitation.

There was a deal of support for involving clients more within the clinics, hearing their views on how the service was run and hearing their concerns.

Clients' Perspective. 28.7% said that understanding from service providers and the general public was needed if addicts were to be rehabilitated.

Choice.

Working in this client centred way requires having available a range of options. As mentioned above, while there was debate about the merits and demerits of any one option, there was agreement that the best policy was to make all available and direct a client to the one most suitable. For example, some clients may thrive best within a therapeutic community of recovering addicts or in a special aftercare programme for addicts only. Others might do better being integrated into an already existing community programme, course or job with non-addicts.

At the end of the day, if client centred work is the path taken, then the proper range of options must be put in place and gaps filled. There is no needle exchange in Dun Laoghaire for example.

Whatever options are developed, there is a need to ensure fast access to each of them.

Staffing and Staff training.

All of this requires the provision of additional staff and staff with specific skills. Examples of this given during the meetings included; the provision of key-workers to work with individual clients and link workers to develop relationships between the service and other players such as community groups.

In addition to the provision of extra staff, training of existing staff to do their current work is lacking. The example was given of General Assistants who receive no training.

Training would also be required for groups and individuals outside of the service who would be developing liaison with clients under a new rehabilitation-focused regime. If Fás for example were offering places to clients, or were developing programmes for clients, staff within that organisation may well need training to be able to respond.

Education of the public.

There was dismay at the lack of support perceived in the general public for the service and clients within it. Where this was raised, participants felt much of it was due to a lack of education. A well thought out, educational media campaign, which would give a more rounded picture of the service and the plight of addicts was advocated.

Methadone.

The issue of how good methadone programmes are as a treatment for opiate addiction was put to the focus groups. This had come up a lot in the interviews with clients in preparation for "The Clients' Perspective". It generated a lot of debate within the groups.

Overall, there was support for methadone as a stabilising agent. There was concern however that many clients are ending up on clinics for too long. The most divisive issue for all three groups was whether there should be a cut-off point for methadone. Some suggested that a client should not be allowed to continue on a clinic beyond a year, especially on high levels of methadone. Overall though, there was serious disquiet at the prospect of turning clients away after any length of time.

It was strongly suggested though, that this debate would become superfluous if methadone had a proper place within rehabilitation. If clients were being challenged and given options, then many might well move beyond methadone.

An interesting observation was made in the Dun Laoghaire meeting, that there had always been .a struggle between the "drug free" camp and the "harm-reduction" camp. At the moment, the methadone way holds sway, but perhaps it was time to strike a greater balance.

A specific concern mentioned was that the lethal mix of methadone and benzodiazepines is being taken by many clients. This results in an ongoing state of confusion and chaos in their lives, which makes constructive engagement in rehabilitation impossible.

The suggestion was made in Dun Laoghaire that alternatives to methadone such as the Black Box method be researched.

Clients Perspective; 46 % of clients are more than a year and a half on methadone. 54% of clients totally support methadone as a way of responding to opiate addiction. 46% support it with serious reservations or are opposed to it. 86% expressed the desire to be totally drug-free.

Evaluation of Services.

The call was made in two of the three meetings for a comprehensive evaluation of services. In relation to this, a number of points were made.

The service as it is today has emerged from its own particular history. There is a need to take account of this history and evaluate how much of the way things are is due to informed decision making or to drifting.

A number of participants described the service as “hotchpotch”. It was felt that taking stock would help to see how the pieces fit together and what gaps need to be filled.

The point was made that there is not necessarily an agreed understanding of the underlying concepts of addiction and of rehabilitation. Perhaps it is not necessary that there should be a consensus, but people needed to dialogue about it and to at least understand where each is coming from.

Any evaluation process needs to be comprehensive, involving all players, including clients.

Appendix 1. Participants in focus groups.

(Names are recorded from hand-written register. Please forgive misspellings.)

Cherry Orchard.

Siobhain O Neill, Nurse, Fortunestown Clinic.

Caroline Costigan, Outreach Worker, Castle St.

Olivia Holden, Clerical Worker, Castle St.

lan McCabe, addiction Counsellor, Tallaght/Crumlin.

Martin Conlon, General Assistant, Castle St.

Veronica Ryan, Senior Outreach Worker, Castle St.

Rose Stoppard, Nurse, Castle St.

Mary Magee, General Assistant, Ashling.

Peter O Quin, Addiction Counsellor, Tallaght.

Jim Doyle, Area Operations Manager, Cherry Orchard.

Veronica, Addiction Counsellor, Tallaght.

Maurice Farnham, Task Force co-ordinator, Tallaght.

Julie C. Education Officer, Crumlin.

Ger Byrne, Addiction Counsellor, Castle St.

Karen Flynn, Outreach Worker, Clondalkin.

Louise, Assistant Area Manager, Cherry Orchard.

Mary Dempsey, Helpline Cuan Daire.

Anne Fanning, Outreach Worker, Cork St.

Anne Kilday, Nurse, Cork St.

Sheila Stone, Task Force Co-ordinator, Dublin 12.

Mike Ryan, C.W.O, Aisling

Marian O Byrne, Nurse, Aisling.

Brendan Colgan, G.P. Cork Street.

Mel Bay, General Assistant. Aisling

A. Tobin. Pharmacist.

Brogan Whittle, Counsellor, Aisling.

Phibsboro Tower.

John O'Reilly, General Assistant (+ everything) City Clinic.

Paul Synnot, General Assistant, Domville House.

Therese O Rourke, Counsellor, City Clinic.

R. Healy, Area Operations Manager, Phibsboro.

Deirdre McCann, Midwife, Phibsboro/ Rotunda.

Sheilagh R. Reynolds, Education Officer, Phibsboro.

Dymphna Dowell, General Assistant, Domville House.

Cathy Walsh, Outreach Worker, Counsellor, City Clinic.

Catriona Brady, Outreach Worker, Darndale.

Dun Laoghaire.

Gerry McCarney, Psychiatry Registrar, Patrick's St.

Siobhan Steed, Area Operations Manager, Centenary House.

D. Mlinazic. General Assistant, Patrick's St.

Victoria Hurley, Patrick's St.

Olivia Byrne, Deputy Area Operations Manager, Centenary House.

Mary Russell, Senior Addiction Counsellor, Patrick's St.

Sinead Bracken, Addiction Counsellor, Baggot St.

Mary Kenny, Outreach Counsellor, Baggot St.

Maeve Shanley, Area Deputy Area Manager, Centenary House.

Helen Johnston, Liaison Pharmacist, Dublin/ South Wicklow.

Mick Quinlan, Gay Men's Health Project, Baggot St.

Colm Quinn, GP, Patrick's St.

Pauric Reilly, General Assistant, Patrick's St.

Steve Harding, Education Officer, Patrick's St

Report 3.

“The Community Groups’ Perspective”

The Views of Community Groups and Organisations working with Opiate Addicts in the Eastern Health Board Area on Rehabilitation.

By Peter Dorman.
July 1999

Report 3; The Community Groups' Perspective.

Introduction and background.

This is a report of a meeting of community groups who are working in the field of drug abuse within the Eastern Health Board area. The purpose of the meeting was to hear the views of the participants on rehabilitation, so as to assist the Health Board's drug service in drawing up a blueprint for rehabilitation.

A list of those who participated is included in appendix 1.

The meeting took place in the context of research commissioned by the Health Board to elicit the views of the community groups, staff of the drugs service and clients of the drugs service, on rehabilitation. The report should then be read in conjunction with the other two reports within this package, "The Clients' Perspective" and "The Staff Perspective."

The meeting was held in the Ashling Hotel on the 30th June 1999. The format of the meeting was as follows:

1. Participants were welcomed and asked to introduce themselves.

2. The background and purpose of the meeting was explained.

3. Participants were asked to think of an individual client that they know well, whom they believe has moved towards rehabilitation, and to write down what, in that person's particular case, rehabilitation means. They were then asked to share this in small groups and, in the light of that sharing identify key elements of rehabilitation; what are we saying when we say that a person is moving towards rehabilitation?

4. Given these agreed key elements, the group was then invited to consider how drugs services, as they stand presently, measure up as services of rehabilitation.

5. Finally, a discussion was invited about specific concrete changes that are required in order to create services that are more services of rehabilitation.

Some key aspects of Rehabilitation identified by Participants.

In considering the stories of addicts who have moved towards rehabilitation, and gathering the learnings from these into a picture of what rehabilitation means, participants identified the following key points.

- Having a place to go that is safe: a place of treatment that is drug-free, where one can belong. A place that is attractive, that one would want to go to. A place where confidentiality is respected.

- Having the opportunity to escape from the environment of drugs.

- Having access to appropriate levels of treatment for the individual's situation. Having access to counselling, stabilisation and harm reduction, to therapeutic communities, and to any services necessary to treat one's addiction.

- Having necessary supports to enable one to avail of treatment, notably childcare.

- Being able to deal with the underlying addiction, and the causes of it, in one's life.

- Becoming well in the context of the family and network of relationships of which one is part. Access of families to the rehabilitative process.

- Having access to training and employment, to meaningful occupation as part of a rehabilitation process.

- Having the opportunity, where appropriate, to achieve re-integration into one's local community, and the supports to sustain this.

- Having access to rehabilitation wherever one is in contact with the state; for example, in prison.

Main themes emerging re developing a rehabilitation service.

Staffing within the service.

While appreciation was expressed at the work so many are doing across the board in providing drug services to clients, a number of desired changes were outlined which would facilitate the development of a rehabilitation centred service.

There was a desire to see standards set for practitioners. The point was made, for example that addiction counsellors did not require any standardised accreditation to practise. In relation to individual projects, it was possible to mask poor practice with good publicity. There was a need, for the sake of the clients, to establish criteria of good practice across the services.

There is a need for more training for staff at all levels in the various services.

There was a call for staff to listen to clients, and to take serious account of their expressed views and concerns. This point was made specifically in relation to doctors.

Closely working multi-disciplinary teams were seen as key to the way forward. Given that rehabilitation must involve many aspects of a client's life as well as

medical needs, various professional disciplines working together are needed to respond.

There is a need for closer liaison between various parts of the service, particularly between clinics and rehabilitation projects, and especially at the point of client referral.

There was much debate as to the appropriate lifestyles of staff in services. Some felt staff should model a lifestyle of abstinence from chemicals. Others felt what was needed was to model responsibility toward the use of drugs such as alcohol. There was no consensus, except that this was an issue that service providers needed to reflect upon and develop policies about.

There was a call for an after hours service from the health board for addicts.

There was a strong call for a "benzo protocol" to be brought in for doctors. People were concerned at the amount of benzodiazepines being prescribed for clients on methadone.

Generally, there was a call for the service to support projects outside of the state sector and to learn from their successes.

Rehabilitation in the early stages.

A view shared by many participants was that rehabilitation was something for clients after they were stable on methadone. It was advocated that clients be challenged with the possibility of rehabilitation from their induction into services. Clients should feel that they could be drug-free, and not get the message that they ought not to hold out hope for such a possibility.

The rehabilitation offered should focus not on living with chemical addiction, but on the root causes underpinning the addiction, whatever they may be in an individual case.

In relation to this. the call for preventative work with young children was also made.

Whose Rehabilitation?

There was some debate about who should set the targets for rehabilitation, the client or the professional. There was concern about imposing standards of normalisation inappropriately. Equally, there was concern about a laissez faire approach that allowed a client to drift in their chaos and confusion.

Consensus seemed to lie in the model of intervention which sought to get a client to the point of being capable of making choices, providing options for progression, and gradually letting the client take more and more power over their lives.

In the light of this. it follows that staff who are in a position to advise clients need to know all the possibilities open to them.

Access and Progression.

The point was strongly made that clients need fast access to all services. Waiting times are too long, and in some stories told, this has meant that people have died.

The argument was made in relation to this that by letting people settle for methadone, potential progression routes are clogging up. The answer isn't more clinics, but a concerted effort to move people off methadone into work, training, residentials, aftercare etc. and allow others into their places.

Access also had to be resourced, and the main example given of this was the need to integrate childcare provision into all services.

Public Education.

There was concern “about the lack of public understanding of the reality of opiate addiction and the services that exist to respond to it. There was a call for an intelligent media campaign to educate the public, which did not stereotype the clients.

In addition to this, a public campaign to promote clean and healthy living in general was desired, as it would lend cultural support for a positive lifestyle that didn’t need chemical abuse for self-fulfilment.

Methadone

Throughout the meeting there was much concern expressed about the over emphasis on methadone. The “methadone mentality” was talked about, where methadone has come to replace any attempts at rehabilitation. It was felt by a number of participants that the service was settling for methadone as a way of containing the problem. Methadone should have a smaller part in the picture and operate in the context of an overall policy of positive rehabilitation.

Vision.

Finally there was a clear call for the development of a vision. The service as a whole needed to take stock and re-evaluate its practice. There is scope to develop a shared ethos, while leaving room for difference, among the various service providers. There is certainly scope to develop progression routes across services and beyond the service into the wider community, and to set down markers of success against which services can be measured.

Appendix 1. Participants.

(Names taken from a hand-written register. Apologies for misspellings)

Willie Rattigan, Eastern Health Board, Dr Stevens

Maria Fox, Canal Communities Rehabilitation Service, Dolphin House.

James Conway, Eastern Health Board, Dr. Stevens.

Jane Bailey, C.A.S.P. North Clondalkin.

Jim Doyle, Eastern Health Board, Cherry Orchard.

Margaret Maher, Canal Communities Rehabilitation Service, Dolphin House.

Margaret Bourke, Eastern Health Board, Southwest Sector.

Declan Reddy, Eastern Health Board, Blanchardstown.

Andre L, South Inner City Local Area Task Force.

Liam O Brien, CARP, Killinarden.

Vincent Doherty, South Inner City Local Area Task Force.

Mona Parker, Youth Action Project, Ballymun.

Angle Potter, Youth Action Project.

Aine Walsh, Cabra Resource Centre.

Bernie McDonnell, Community Awareness of Drugs, Central-Hotel Chambers.

Fergus McCabe, North Inner City Drugs Task Force.

Summary

Eight key points raised by the three reports.

1. There is an urgent need to re-evaluate the service, especially questioning the place of methadone, which does not appear to be operating within a rehabilitative framework.

2. Rehabilitation needs to be comprehensive, considering all aspects of a client's life, especially their relationships, accommodation, contact with the law, basic resources such as money and food, and the personal issues underpinning the addiction.

3. Rehabilitation needs to be client centred, taking each as a different case with different needs.

4. Rehabilitation needs to be delivered within the context of an integrated multi-disciplinary service.

5. Rehabilitation needs to offer a range of responses to cover the range of needs, well resourced with fast access.

6. A major public education programme is needed if a climate conducive to rehabilitation is to be achieved.

7. Rehabilitation needs to be participative, engaging clients in appropriate levels of decision making and allowing recovered addicts to play a part in designing and delivering the service.

8. Rehabilitation needs to offer hope. 86% of clients say they want to be drug free. What is our response? Do we believe them? Do we believe that it is possible for them?

Appendix A

About the Researchers.

Lynsey Jones is currently concluding a masters in Social Policy at U.C.D. She has worked as an assistant researcher on a number of studies including social policy analysis for the National Women's Council and drugs awareness for the Blanchardstown Drugs Task Force. Lynsey lives in Dublin.

Peter Dorman works as a freelance facilitator and community educator. He has worked in the area of community development and youth work for fourteen years. He is from Dublin but now lives in County Louth.

Appendix B.

Limits and Scope of this research.

This piece of work offered some key challenges. Chief among these were;

- The challenge to seriously engage the clients of the drugs service in reflecting upon the concept of rehabilitation.
- To collect a comprehensive range of data about clients within a limited timeframe which allowed only for one short interview per client.
- To process a large amount of data from three distinct perspectives, that of clients, staff and community service providers, and to retrieve a congruent picture of the current issues in relation to rehabilitation.

The time allowed for the study accentuated these challenges. The work was contracted at the beginning of June and completed at the end of July 1999. Getting resources into place meant that it was the end of June before interviews began to take place. The shortness of time raised some questions which are discussed below.

Initially, it was hoped to contact a random sample of clients in advance and ask them to participate in the survey. It was hoped to ask staff in clinics to help in this preparatory work. As it turned out, there was no time for this. The researchers turned up at clinics after arranging a visit by telephone. Making this arrangement was often complex, as named contacts were often hard to get in touch with-and decision making within clinics about allocating rooms was often a slow process.

Once in the clinic, the researchers elicited the help of pressurised staff to help secure interviewees. A great tribute is due to the staff for the interest they showed and the efforts they made to accommodate us. With randomness in

mind, we initially tried to take names at random from appointment lists for the clinic session and. only see those clients. However, this was very inefficient time-wise as clients often came in bunches or didn't turn up at all. The researchers were either waiting around for a named person to turn up or trying to persuade those who were queuing to wait twenty minutes for the preceding interview to be completed. To achieve the required sample, this approach would have required twice the time.

In the event, one researcher assisted by G.A.s approached clients in the waiting room and invited clients to participate.

Great care was taken to retain randomness in this approach. The researchers were aware of the dangers of only approaching the most friendly, curious or talkative clients. People were approached more or less as they came in the door and as the interviewer became free.

Notwithstanding all these efforts, it remains the case that participation in interviews was voluntary, and depended on the willingness and ability to volunteer. Clients had to leave the waiting room and agree to be escorted to a room upstairs in the clinic to be interviewed by a stranger about "rehabilitation" and their life's story. No doubt some would find this difficult, particularly women, as the interviewer was usually male.

It is probably true then, to some extent at least, that the clients interviewed were "together" enough to undertake this task. Offsetting this, it was very helpful to have two researchers on the scene, one in the waiting room spending time chatting to clients, gaining their confidence, supported by G.A.s and the second interviewing. The waiting room researcher played a key role in reassuring clients who lacked confidence.

The report "The Client's Perspective" should be read with this in mind. It is the opinion of the researchers that it would be grossly unfair to dismiss the research as being just among the "cream of clients". But probably the most chaotic were not highly represented. It should be said though that the

researchers experience of the clients was overwhelmingly that of a willingness to participate, a generosity in giving time, and courtesy.

In the light of this experience, future research organisers should consider the following possibilities.

- More time, probably six months rather than two would have been appropriate.
- Staff in some clinics suggested that perhaps it would be best if they did the research, as they know the clients. There is an obvious difficulty in this, in that two outsiders have no power over the clients, in terms of cutting methadone if the client were to reveal they were cheating on the clinic. Furthermore, staff would have to guard themselves against becoming defensive about criticisms of the service, or filtering what a client says through impressions previously formed about them. However, staff, especially G.A.s, could collect a lot of the research information over a more relaxed period of time. It might be useful to engage staff in a process of designing and conducting research, perhaps with outside assistance.
- Research could be undertaken in other settings where clients gather. The drop in at Anna Livia was ideal for research. The staff were extremely helpful (as indeed they were in all the clinics) and because the place is a drop in. clients are not necessarily just in and out and too busy to see an interviewer.
- Apart from the confidential one to one interviews, the research could usefully include focus groups, even informal ones in waiting rooms, especially on the views of clients on rehabilitation.
- There is much scope for talking to clients in local community projects, residentials, drug-free projects and individuals who are well recovered and reintegrated into local communities. Very little was done outside of clinics due to the time factor.

- Interviewing clients in prison should be considered.
- It was decided on this occasion not to offer clients payment for their interviews. In the light of our experience, it may be worth re-considering this decision. Perhaps if clients were offered payment, a wider cross section would be secured.

The researchers are happy that a balance was struck between quantitative and qualitative research. Measurable indicators were used and consistency of questioning was adhered to. Yet care was taken to engage clients in conversation and record as much of what they said as was physically possible. It was important to communicate that we were keen to hear from them and not just to hear facts *about* them.

The focus groups worked well, though there were some communication difficulties, especially in the North sector, where a number of staff did not appear to receive the invite. Invitations were at short notice also, again due to the tight deadline.

The community group meeting went well, though the attendance was disappointing. It would have been interesting to interview service deliverers in their places of work as well as in focus groups. Again, time made this impossible.

In conclusion, this research went better than expected, but the timeframe limited its capacity. In terms of laying the basis for a blueprint for rehabilitation, it most likely represents a lot more than a straw in the wind, but probably less than a definitive statement.

Section 3. Summary of findings of this research.

An analysis of the data contained in this report will help outline some of the factors, which should be taken into account in constructing a blueprint for rehabilitation. Chief among these factors are the following.

- Clients, for the most part, live in close contact with family, extended family, partners and children. These networks of relationship are at once their greatest source of support and motivation, and their greatest source of conflict and distress.
- Almost all of those in stable relationship regard their relationships as supportive. Many also see their children as the reason both to get clean and even to remain alive. There is an opportunity to build on this strength in terms of rehabilitation, by including partners and children in rehabilitation processes.
- The question must be asked, in the light of the above, is the individual addict being treated in isolation, without considering the tight network of relationships of which they are part?
- Many clients feel insecure in their accommodation, and find it hard take a positive attitude towards anything while living in cramped conditions and an atmosphere of tension. Those who are homeless face an impossible task when it comes to recovery from a serious drug habit. The question of secure, decent accommodation, with adequate space, is a fundamental one when it comes to rehabilitation.
- For the majority, the experience of school was poor. The key factors here appear to be its perceived irrelevance, an authoritarian atmosphere, and its damaging effect on self-belief. The design of programmes can learn from this experience. Courses subsequent to school have proved more popular, especially when they hold out a prospect of work and income, and are compatible with the skills and interests of the individual.

- It should be remembered that nearly everyone who took an examination in school passed it, even when feeling unmotivated. This group is not a group of incompetent people. One could speculate as to whether this data indicates that these individuals will only tackle something if they feel they will succeed at it.
- Without a doubt, constructive, meaningful, rewarding occupation is key to rehabilitation. However, many clients feel unconfident and unable to achieve their ambitions. Many are very clear on what they want, but feel it is just out of their grasp. Sensitive, skilled, individual coaching seems appropriate here, in the context of rehabilitation.
- The reality of many clients is a daily experience of deep unhappiness. Many are coping with horrendous burdens of family break-up, poverty, suicide among family and friends and sexual abuse. These deep personal issues need to be taken into account. The evidence from those who are experiencing successful rehabilitation programmes is that dealing with these issues through a combination of counselling and peer support is key to recovery.
- Almost all of the clients are poor. 61% are living only on social welfare. Resourcing their recovery adequately is a prominent question. A glaring example of this is childcare. 80% of the women do not eat a good meal regularly. Many remarked that they miss meals so the children can eat. If such women are to undertake rehabilitative occupation such as work or training then their childcare needs must be resourced. One client was enthusiastic about childcare programmes that would incorporate preventative education.
- Rehabilitation needs to include education for, and resourcing of, a healthy lifestyle, including active pursuits and good diet.
- Rehabilitation should not be equated with abstinence from certain chemicals, though for most that is an essential element. The evidence of some older clients who have had long periods of abstinence is that that is when the real work starts. That is when the reality sets in, that in the end “I live with myself”.

- In terms of the chemical side though, there needs to be a wider focus than just on opiates. A comprehensive rehabilitation needs to take into account the use of alcohol, cannabis and benzodiazepines along with the opiates, including drugs being prescribed.
- The opportunity which prison sentences afford for rehabilitation is being missed. This applies both in terms of the non-availability of a real service in the institutions and a failure to link up with services on the outside. None of our group became drug free in prison and survived more that a fortnight on release.
- Clients are asking for respect. They feel the stigma from the general public as expressed through protests over clinics. A rehabilitative climate needs to be created, where the public are educated about addiction and the lives of people who are addicts. If the public supported addicts, rehabilitation would be so much easier.
- Methadone is a valued part of the service, but the question arises; methadone for what? 86% of the sample want to be drug free. Rehabilitation needs to challenge them to work for that target but also to challenge the service to respect the target they the clients are setting for themselves. Methadone needs to take its place within a planned service, which works closely with the clients, is flexible to meet their individual needs, and provides the breadth of options needed to respond to the variety of need.
- Clients want to be involved in shaping rehabilitation. They wish to see clean recovered addicts playing a role in delivering the service. Indeed many of them have ambitions to work in it themselves some day. At the very least they want to be listened to by people who have the time and interest to listen, and the power to respond to what they are saying. Many expressed gratitude that, even in some limited way, this research asked them what they thought, and they expressed the wish that some good would come of it.

Appendix 1. Interview schedule.

Rehabilitation research interview. Private and confidential.

Name. (initials)

M/F

Address. (postcode only)

Date of birth.

Date and time interviewed.

Venue for interview

Rehabilitation.

This section is an open conversation about the interviewees' ideas about rehabilitation with questions such as these as a guide.

What is your realistic ambition regarding drugs? Do you want to be drug free?
What's the worst thing about being on drugs?

What are the main things that are helping you with your drug problem? What would help you, with your drug problem?

What are the main barriers stopping you getting over your drug problem?

What advice would you give to anyone who wants to help you with your drug problem?

What does the government need to do to help people in a situation like yours?

If there were a training course with things like job skills, personal development, art and crafts etc. would you attend it? Why? Why not?

Accommodation.

What type of accommodation do you have?

How do you find living there?

(excellent...good...fair...poor...very poor.)

Who do you live with?

Have you, your partner or family members ever been asked to leave your accommodation?

Education.

At what age did you leave school?

What was school like for you?

(excellent...good...fair...poor...very poor.)

Did you do any exams? How did you get on with them?

Do you have any trouble with reading or writing? On a scale of 1 to 10 how good is your reading and writing?

Have you done any other training or courses? How did you find them? What has helped you most? Is there any training or courses that would interest you in the future?

Family.

Do you have contact with your family members now; (mother, father, brothers, sisters?)

Are your family supportive of you? Do any of your family members have problems with drugs or alcohol?

Do you have any children? Who are they living with at the moment? Do any of them have problems with drugs or alcohol?

Are you in a stable relationship with anyone at the moment? Do they have any problems with drugs or alcohol?

How is that relationship?

(excellent...good...fair...poor...very poor.)

Forensic.

Have you ever been in trouble with the law?

Ever been in prison?

Did, you get any help with your drug problem in prison?

Did you ever do any study, art crafts or drama in prison? Did any of that help you in any way?

Health.

How is your health?

(excellent...good...fair...poor...very poor.)

Have you felt low (to the. extent that it interferes with your functioning) in the past 30 days? How many days?

Over the past 30 days, have you thought of ending your life? How many days? Have you made any plans?

Have you felt anxious, tense, butterflies, fearful in the last 30 days. How many days?

Have you had panic attacks? Intense anxiety, difficulty breathing, heartbeat racing? How many days?

Are you on any medication, besides methadone?

Do you take exercise? If yes, how often? What type of exercise?

Do you eat a lot of sweet things; do you binge much?

Do you eat a hot meal every day?

Have you ever been tested for blood borne disease? What was the result?

Social life

How do you spend your time? Do you have any hobbies or interests? Do you play sports?

What talents or skills would you say you have?

Do you have many close friends? Are they drug users?

In the past, did you have close friends who are not drug users? Did you play sports?

Employment/ income.

Are you in paid employment; paying PRSI? If yes, are you satisfied with your job?

(very satisfied....satisfied.....unsatisfied,...very unsatisfied.)

Have you ever been in such a job?

What problems have you encountered in previous employment? Have drugs interfered with your work?

Have you done any job interviews, prepared a C.V., applied for jobs?

Have you ever had career guidance?

Would you say there are jobs “out there” that might suit you?

What are your current sources of income?

Could you see yourself in a job? What sort of job? What would you need to get there? What’s stopping you getting there? Any course or training that would help?

Drug history.

What age did you start taking any drugs?

At what age did you start taking opiates?

How long have you been on methadone maintenance? Is it helping you in your life?

How did you-get into drugs?

Have you ever been drug free? Under what circumstances? Under what circumstances did you return to drug use?

Drug use in past 30 days.

Type	Yes/no.	No. of days	Amount	Route 1. Oral. 2. Sniff. 3. Smoke/chase 4. Intravenous.
Alcohol				
Heroin Smack, Gear.				
Illicit Methadone				
Illicit **benzodiazepine.** Valium Roche Diazepam Librium Dalmane Rohypnol	«			
Cocaine Crack/ rock cocaine				
Cannabis				
Amphetimines. Ecstasy/ speed.				
Antidepressants Prothiaden (P75) DF118s.				
Other				

Appendix 2. Index of tables.