

DUN LAOGHAIRE RATHDOWN REHABILITATION SURVEY

A SURVEY OF CLIENT PERSPECTIVES IN REHABILITATION

COMMISSIONED BY

DUN LAOGHAIRE RATHDOWN DRUG TASK FORCE

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INTRODUCTION

Aims and Objectives

The Dun Laoghaire Rathdown Drugs Task Force wished to conduct a survey of existing service users to determine their level of satisfaction with the existing service. A secondary aim of the Dun Laoghaire Rathdown Drugs Task Force was to identify appropriate interventions - from a users perspective- that could be included in submissions to the Local Drugs Task Force Service Plan for 2000.

It was decided at initial briefings that a provisional questionnaire would be drafted, in a style similar to that of an Eastern Health Board-commissioned survey conducted in July of last year (Dornan, 1999). It was agreed that certain demographic characteristics of clients would have a significant bearing on their views of rehabilitation.

These demographic characteristics included:

- Gender
- Age
- Length of time attending current service
- Accommodation
- Education to date
- Current employment status
- Forensic history
- Current physical health

Aspirations regarding future drug status were also to be surveyed, along with several items pertaining specifically to rehabilitation.

In summary, the main aim of the research was

- (a) to establish the demographic profile of those seeking rehabilitation within the Dun Laoghaire Rathdown borough
- (b) to determine the implications of this profile for such rehabilitation.

This aim was to be met by surveying a range of clients availing of distinct services within the Dun Laoghaire Rathdown Task Force area.

Methodology

The main methodology used was the questionnaire. Clients were encouraged to sit with the researcher in a private area and the researcher either gave the questionnaire to the client to complete or the researcher read the items to the client who then indicated their response.

It should be noted that the items regarding demographics above were the items from the original draft questionnaire administered in the Pilot Study (see report in Appendix 3 for further detail); Several items were added and others modified after the Pilot Study was conducted. Additions and modifications were made following input from a variety of sources including the Task Force Co-ordinator, the ECAHB Area Operations Manager, the Senior Outreach Worker, the Senior Addiction Counsellor, members of the Rehabilitation Sub-group and the Chairperson of the Drugs Task Force.

The main additions pertain to:

- Qualitative data: additional data was requested in the final questionnaire regarding client opinion on the quality of their accommodation, their level of job satisfaction if employed, etc.
- Physical Health: there were a further 4 items in the final questionnaire that gave a more detailed picture of the physical health status of clients
- Social Support: there were an additional 7 items in the final questionnaire regarding peer, family and partner support.

The language of some of the items was also changed to enhance understanding.

It was decided that a broad range of perspectives would be solicited and as such, this report reflects the variance in attitude. The clients attending Patrick Street, the Oasis Project, the Pathfinders Group, the satellite clinics and the GP caseload are all at very different stages in the course of their drug use. To collate all of the data into one whole would mean that the diversity of perspectives be completely lost. Demographic characteristics are therefore separate for each of the services, whereas views on rehabilitation are discussed altogether.

it should also be noted that the original intent - to survey client attitudes purely through the questionnaire method - was insufficient. Participants whose literacy levels were poor and who preferred to have the items read aloud by the researcher, responded to this situation in the following manner. Items that had the scope for an individual response were at times used by the participant as a more informal question - answer session, where there was a certain amount of expansion by participants.

We have included these comments made by the participants for a number of reasons:

- The comments enrich the report a great deal and reflect more than adequately the genuine voice of the client availing of services
- The inclusion of comments as they have been made allows the reader a look at information untainted by any bias / experimenter effect

Resources

The primary resource used in this survey was the questionnaire.

Any Special Concerns

Arising from initial discussions and of course the Pilot Study, it was noted that the levels of literacy within the surveyed population were varied. As was noted above, this obviously necessitated modifying the methodology used: certain clients needed the items read to them and the researcher then filled in the questionnaire. This was a less-than-ideal situation.

As has been outlined above, literacy levels led to a modification of the methodology used. The rigid structure of the questionnaire was made slightly more flexible and additional comments made by the participants were included in the collation of the data. This is particularly noticeable in the data collected from the Pathfinders project, where there was sufficient time and space to engage each client. The level of detail collected from this group is therefore higher when compared to data collected from other sources.

The level of stability of the participant being surveyed was also of special concern. The chaos that is characteristic of some drug users at a specific stage would make a coherent interaction regarding rehabilitation difficult.

This situation was obviously unavoidable and it was felt the best way to deal with this was to be as sensitive and responsive to participants as possible. Previous experience with such a special population was essential.

It must be noted that the expected target figures were not reached. This was due to a combination of factors - the time frame of the research, the availability of space, the frustration and apathy towards services by clients and other unforeseen circumstances. The total number surveyed (63) does, however, present a wide cross section of opinion and the detail of information collected is high.

Background of Services Provided in Dun Laoghaire Rathdown

Access to the service provided is currently through any of the following:-

Oasis Project

This is a community-based rehabilitation project based in the Mountwood/Fitzgerald area. It was established in January 1998 as a response to the needs of those affected by drug use, both indirectly and indirectly, and to provide an ongoing service of support to individuals, their families, and the wider community in addressing drug related issues.

In January 1998, operating as an Eastern Health Board Satellite Clinic the Oasis Project provided addiction counselling. The voluntary Management Committee of the Project applied for and secured FAS funding to establish a Community Employment Scheme for drug users in the area. The scheme was to involve a programme of education; rehabilitation and support, to enable participants take control of their own lives and their drug use.

The Scheme began with the employment of an Administrator and a Support Worker on a Community Employment Scheme. They built up relationships with clients of the Satellite Clinic and gathered information for the Project

The first three weeks of the programme focuses on:

- Identifying needs
- Setting group rules
- Establishing confidentiality
- introduction to facilitators
- Relationship building between staff and participants

Depending on the needs the programme includes:

- literacy modules
- work skills
- budgeting skills
- persona! development
- first aid
- health & leisure

There were 6 participants on the project at the time of the pilot survey.

Pathfinders

Pathfinders are a group of recovering drug users who all but one attend the Patrick Street Clinic and who are on a methadone maintenance programme. They range in age from 24-37 years of age and there are equal numbers of males and females.

Pathfinder Project is an education and training programme for people in recovery from drug use in the greater Dun Laoghaire area, aimed at enabling them to re-enter mainstream society.

In 1997 a local community group got initial support from the Southside Partnership Drug Sub Group to run a pilot project involving recovering drug users attending the Patrick Street Treatment Centre, Dun Laoghaire. This took the form of a leisure programme which ran on a part time basis which was facilitated by two voluntary workers under the guidance of the Senior Counselor in' Patrick Street. A multi agency committee was then brought together to look at the possibility of setting up a Community Employment scheme. The Dun Laoghaire Rathdown Outreach Project was set up and manages a number of Community Employment places allocated under the National Drugs Strategy Teams programme. The participants are now employed through the C.E. scheme for 19^h hours per week.

The current programme offers participants the opportunity to avail of the following:

- Computer Training
- Discussion Groups
- Personal Development
- Stress Management
- Job Skills Club
- First Aid
- Leisure Days including swimming, bowling, outings etc.
- Group Meetings

Satellite Clinics and General Practitioners

There are two other access routes to services - the satellite clinics and the GP surgeries. These clinics are aimed at local service users wishing to access treatment programmes. The satellite clinics operate outside of the normal 9.00am - 5.00pm routine. At the time of the survey there were 2 satellite clinics operating in the Task Force area, one in Dundrum and one in Sallynoggin, The clients attending the clinics and the GP surgeries tended in the majority to be quite stable in their drug use, relative to clients attending Patricks Street and Pathfinders.

Executive Summary

Recommendations

1. Clients were also calling for a stranded service, or at least potential participants in any future programme would meet certain criteria. This fits in with the “streamed” view of clients that has been taken by the Health Board. The Board proposes four categories of clients - unstable, stable, detox and drug-free and recommends different kinds of services most suitable to each stream. The findings of this survey would certainly indicate that it is not only the service providers making these distinctions. The survey provides support for the hypothesis that streamed services would be more effective, and the recommendation is that such services be implemented forthwith.

It was also remarked upon that services maintain visible links with one another, so that clients can see a clear progression through the services on offer as stability is attained, maintained and increased. These links should be two-way, in that clients who progress from Patrick’s Street to a rehabilitation programme, and who then become destabilised, are linked back in to Patrick’s Street

2. Many clients advocated the smaller, locally based clinics. The demand to be switched from the clinic in Patrick’s Street to these clinics was noted as being quite high. Clients expressed the belief that exposure to others at various stages of stability was detrimental to their own stability and the perception was that quite stable users primarily attended the satellite clinics. Some of the clients in Dundrum particularly emphasised their satisfaction with attending the satellite clinic there, as there were apparent difficulties involved in getting to Dun Laoghaire.
3. It is recommended that any future rehabilitation programmes be supported by a formal advisory committee. This rehabilitation programme could therefore comprise of a management committee providing the services and an advisory group for this committee. The advisory group could include representations from the Gardai, probation service, childcare, local authority housing, the medical profession, social workers from the health boards and the funders of the project. It is recommended that there be a seamless interface between the advisory group, the management committee and the day-to-day management structure.

The main function of the advisory committee would be to advise the management committee at quarterly briefings, to act as a link between the workers and clients on the programme (as the designated liaison from the above agencies) and to act as a resource for the workers on the programme. An example of this would be a worker encounters a client who is being threatened with eviction from the local council. This threatened eviction has of course serious implications for the stability of the client. The worker can avail of the expertise of the advisory committee in dealing with this situation.

The benefits of such a system are that it responds to the many needs of clients expressed in the research. These needs include:

- multiple levels of support on a variety of issues
- clear and concise information pertaining to health / social welfare / legal entitlements / etc.
- proactive services which have planned and resourced for as many varied outcomes as possible.

It would also benefit workers to give them a clear communication structure with other agencies.

4. It is vital to establish and foster formal and strong links between different service providers to serve the client as efficiently as possible. Each service provider is aware of a separate facet of the client context / state and communication between these providers needs to be prioritized. All of these agencies are, however, working towards a common goal. Sometimes one can be left “out of the loop” and valuable information (e.g. whether a client is stable enough to attend and participate positively or not) is lost. Furthermore, these existing resources already in place for the client must be maintained and strengthened and it is only through formal communication links that this will be possible. It is the multi-disciplinary team that works well together and shares information (while maintaining the necessary confidentiality, etc.) that gives the most holistic assistance to the recovering drug user.

It is further recommended that an allocations group representative of referring workers be set up. This should include the GPs, the counselling service, social workers, outreach workers, the community welfare officer and any other relevant agencies. This group would have ongoing input into the selection of clients who would attend any future rehabilitation programme. The benefits of this kind of system include that an informed choice would be made in the selection of future participants for any future programme.

It is important to note that each of these providers would have a significant impact in a successful programme in any case—the GPs inputting health education / promotion, the counselling service giving counselling, the social worker advising on pertinent, immediate issues, etc. The participants in the survey requested that information and awareness on health and social welfare entitlements be highlighted.

5. One consistent and important outcome of this research is client satisfaction with the GP service, both in the clinics and the surgeries. Not only did many clients specifically state (in an informal context) that the GPs were extremely helpful, but doctors were also observed interacting with clients in an atmosphere of trust and mutual respect. This must be acknowledged and also utilised. The GPs have many significant offerings to make to the development of the service and are interacting with clients on a regular one-to-one basis. A further recommendation of this report would be that the GPs should be consulted and have an increased input into the future development of services.

Clients appear to have overestimated their physical well-being. They have unrealistic perceptions as to how healthy they are, although commentary must be restricted to the clients attending the clinic in Patrick’s Street. It has been brought to the attention of the researchers that the number of clients with Hepatitis C in this clinic is approaching 90%. Currently, services relating to treatment of this disease are relying on the innovations of GPs treating clients at the clinic, it is recommended as a priority that a small pilot scheme be put in place to formalise the existing link between Patrick’s Street and the Hepatology Unit in the local hospital.

It would also be recommended that health education play a substantial role in any future rehabilitation programmes. Of the five clients who voluntarily revealed their Hepatitis C positive status, one commented that she was not sure what the disease was or how to seek treatment. Since this treatment can dramatically reduce chances of

cirrhosis of the liver or other serious liver diseases later in life, clients should be made aware and consistently up-dated on health promotion practices. Other issues that could be addressed in such a module include: HIV / AIDS, vaccinations, dental health and screening for cervical cancer.

6. Participants have also triggered recommendations for the content of such a programme. It is believed that a holistic approach to the client reflected in the structuring of the programme above should also be again reflected in the kinds of activities the clients will engage in while on the programme. Clients need first of all to feel a sense of ownership and responsibility for the programme and this would need to be facilitated from the outset.

It has been suggested that a “menu” of activities could be made available to clients and they could then select and design (with input from their case worker) the rehabilitation course best suited to them. Obviously, certain options on the menu could be mandatory in that each client participates in a life skills session for example. They could, however, have a choice of elective modules that allowed a certain amount of negotiation on their part. Adults learn best when they have an input into their own learning and negotiating their own choices with the service provider means facilitates this. This system also allows for the fact that each group that attends a programme has distinct needs and wants. Just because a particular programme worked with one set of clients does not mean that such a programme would be equally successful with another.

Modules that could then be included when such ownership has been established include: nutrition and diet, literacy, numeracy, IT skills, social skills, parenting skills, relaxation training, addiction education, physical activity, art, etc.

The content of the programme must necessarily include scope for the inclusion of partner and extended family and children. It is crucial for any future rehabilitation programmes to build on support systems that are already in place, rather than compete with these supports. This building on existing resources necessarily implies a recognition that each client does not exist in isolation but actually functions in an extremely complex familial and wider social context. Adequate childcare provision, parenting and childcare programmes, family groups, co-counselling, user and partner support groups, etc would meet this need.

It should be noted that attention has been drawn to the number of parents with young children attending the clinic in Patricks Street. This group are a high-risk group, in the sense that the children are at a variety of social, emotional and health risks. It has also been noted that the current help available for these children is divided between many agencies and the kinds of integrated, multi-disciplinary approaches outlined above _ would also benefit these children.

7. At the initial Pilot Study stages the researchers noticed that a significant number of the participants were illiterate or had serious difficulties comprehending the admittedly elaborate language of the questionnaire. It became obvious over the course of the survey that many of the participants were extremely self-conscious of their ability to

read and write. High self-esteem is the backbone of successful rehabilitation and illiteracy threatens this esteem.

High levels of illiteracy are commensurate with the educational disadvantage experienced by these clients. It is critical that any future rehabilitation programme addresses this disadvantage with a degree of urgency. A significant number of clients wish to seek gainful employment at the end of their rehabilitation, and indeed this is part of the recovery process. Having little experience with the school socialisation process, never mind the attainment of qualifications, will undermine employment opportunities.

8. A high number of clients (indeed most of those who indicated that they were unemployed) identified boredom as the main barrier in their recovery and employment support as an aid to improving their lifestyle. This must be qualified by recognising that many of these clients are not at a stage where such support would have any meaning.

There are a number of issues to be considered here. The first is that concern has been expressed that clients seek to enter rehabilitation schemes partly because of the remuneration involved. Some of these clients are not in fact capable of maintaining the kind of stabilisation necessary for attendance and participation on such a scheme. The fear would be that these clients would cope with the demands / attendant stress of the programme by returning to drugs. Not only is this individual now at risk, but he / she is also jeopardising the stability of others who are attending the programme. It is thus recommended that each potential participant be adequately assessed prior to his or her acceptance onto the programme. Such assessment would necessarily include the kinds of communication outlined in Recommendation 4 above.

The second issue to be considered is that while some clients recognised that they were not ready for the level of stability needed to receive employment support, the majority did not. The general consensus was that if the client had a job, they would just stop using. This erroneous belief needs to be taken seriously by the service providers. Clients may become frustrated if they feel that they are requesting employment support and not receiving it. The onus is on the service provider to deal with this kind of client as sensitively as possible, so as not to damage the obvious good intentions. The clients themselves also need to be supported in making realistic self-assessments on their readiness for further training, education and development.

The third issue to be considered is the fact that the sample surveyed recognised that they were not attractive in terms of potential employee status. Clients are well aware that their drug use, poor education background, lack of employment experience and possible criminal record all work against them when they decide to seek employment. These factors can be compounded by the fears and difficulties that can be experienced when leaving the relatively protective atmosphere of the rehabilitation programme. Client self-confidence and self-esteem may be damaged by any rejections they may receive when seeking employment.

It is therefore recommended that a sheltered employment initiative be established as a final phase of recovery for recovering users. Clients would benefit enormously in a number of ways:- job-specific skills and content knowledge would be vastly improved.

and clients could have input into a number of other areas. Such an initiative would also equip the person with team skills, decision-making and problem-solving skills, assertiveness, communication skills and time management. These competencies would be developed in a supportive atmosphere that was threat-free and safe for the client. It has the additional advantage of making the client an attractive potential employee, while instilling confidence to seek employment

9. When determining the clients' perspective on the current service being provided, it was noted that a significant number of comments were made specifically in relation to the counselling service. It must be first noted that clients who were very stable on a methadone maintenance programme did not, on the whole, perceive their need for counselling as being urgent. However, the Pathfinders group in particular and the Patrick's Street clients, to a lesser extent, recognised the importance of the counselling service in their recovery. The service appears (from the clients' viewpoint) to be stretched to capacity, undermanned and limited in resources. It is therefore recommended that the counselling service be better resourced, expanded and more intensive.

CLIENTS ATTENDING THE CLINIC IN PATRICKS STREET DEMOGRAPHIC CHARACTERISTICS

Gender

The following is a breakdown of gender of the service users from this group:-

Male
15

Female
10

- Three of the participants surveyed did not indicate their gender.

Age

The majority of service users surveyed in this cohort were in the 21 - 25 years age group

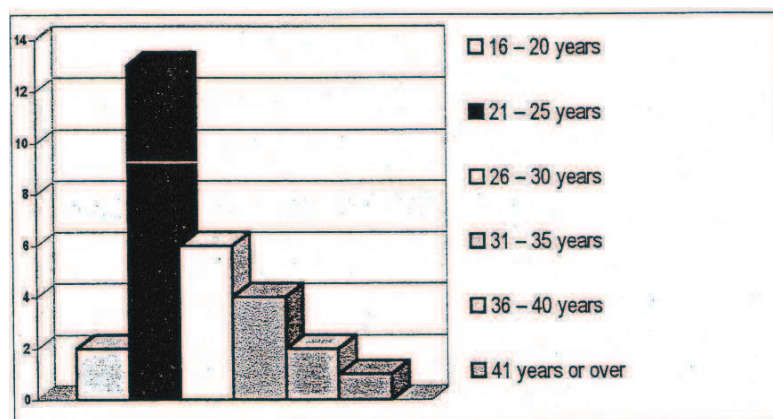


Fig. 1 – Age Profile of St Patricks Clinic

Length of time attending Current Service

There is huge variation amongst this cohort, with roughly 34% of the group coming on to the service in the last 6 months; the remaining 66% (approx.) have been attending Patricks Street for periods longer than 6 months.

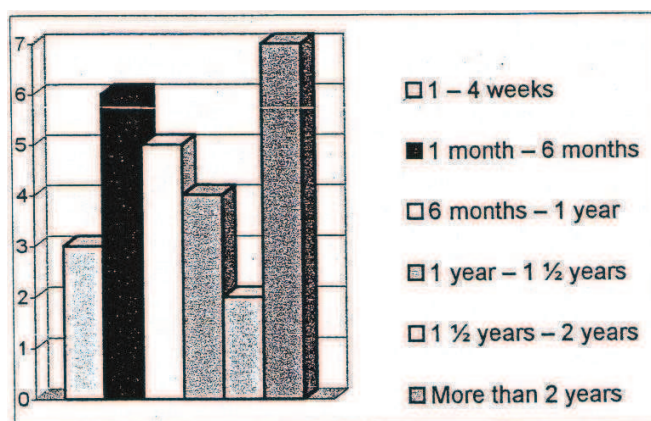


Fig. 2 – Length of time in Patricks Clinic

Accommodation

The majority of service users in this category indicated that they are living in the family home

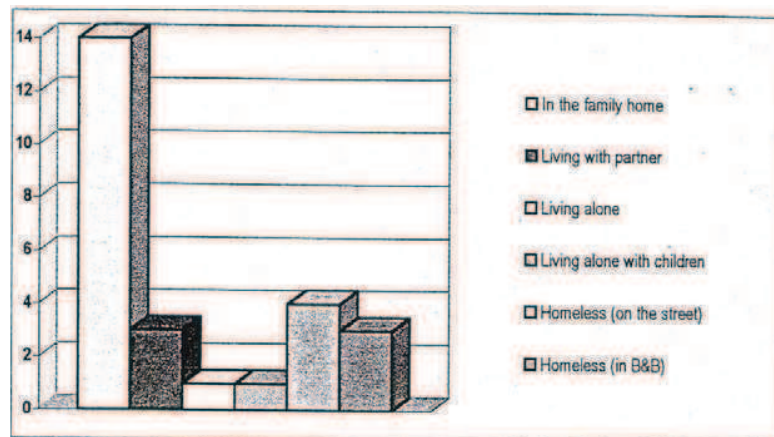


Fig. 3 – Accommodation for Patrick's Clinic

- 6 participants rated their accommodation as excellent 2 participants rated their accommodation as good.
- 8 participants rated their accommodation as ok. One of the participants who commented that her accommodation was ok has been on the housing list for a considerable period of time.
- 4 of the participants commented their accommodation was poor. Two of these participants indicated why - one was living in the family home with a father who was an alcoholic (his mother is dead) and the other stated that she is homeless and constantly being offered drugs on the street
- 6 of the participants rated their accommodation as very poor. Half of these gave a reason for their response - one stated that the B&B was very small, her baby has asthma and there were no facilities there. Another stated that the B&B had no facilities; she was out walking with her children from 10am until 6pm everyday with nothing to do. One participant said that her accommodation situation was very poor as she had so little contact with her son.
- One participant did not rate their accommodation.

Education to date

Only three of the service users in this category have achieved Leaving Cert standard of education.

Eleven of these participants had attended a FAS course, but did not specify on what type of course.

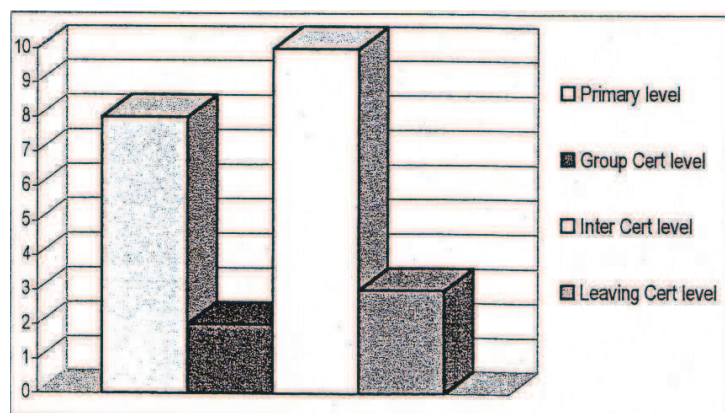


Fig. 4 – Education to date - Patrick's Clinic

- Six of the participants had attended FAS courses, in the following disciplines:
 - catering
 - woodwork
 - metalwork
 - gardening
 - computers
 - industrial skills
 - painting and decorating
- One of the participants had participated in a CERT course, but did not specify in what
- One of the participants on a FAS scheme had also attended a football-training course.
- One of the participants had a City & Guilds qualification in catering.
- One of the participants had attended an industrial skills vocational programme for 2 years.

Current Employment Status

The majority of those surveyed indicated that they were unemployed.

The client in full-time employment was dissatisfied with their job, commenting that if she got proper training she could have a better job than cleaning.

The participant on the scheme indicated that they were satisfied with the scheme but did not indicate why.

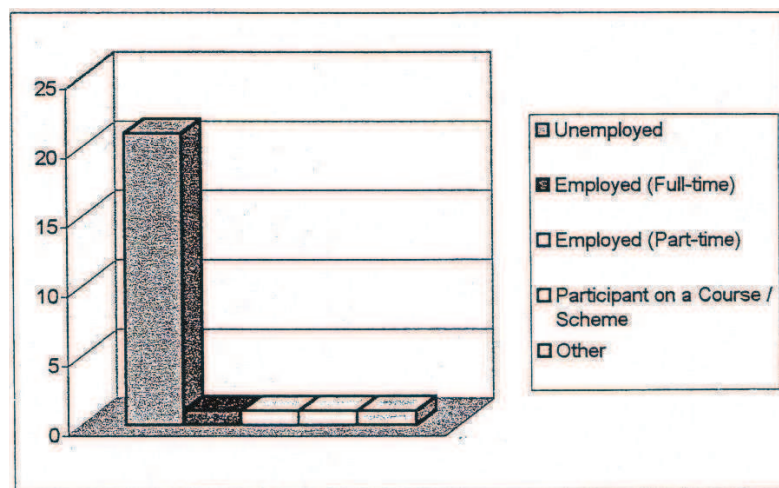


Fig. 5– Current Employment Status – Patrick's St.

- One of the participants indicated that they were disabled in this section.
- One of the participants did not indicate their employment status.

Forensic History

14 of the participants had not spent any time in prison. The rest of the group responded as follows:

- One participant was in prison for four months, where she received a detox. She rated this as of some help.
- One participant commented that they received a total of eight sentences, and that their first exposure to drugs was while inside. This participant did not receive any support in prison.
- One participant spent five weeks on remand and did not receive any support while inside.
- One participant spent two weeks inside but was not on drugs while there.
- 1 participant spent two years in prison where they received five days of physeptone and rated this as not helpful at all.
- 1 participant did not indicate the length of sentence but received a detox that was of some help.
- 1 participant spent 23 years inside, and received a detox that was rated as not helpful at all.
- 1 participant received different sentences (the longest time served being 18 months). They said that they had received very little support that was rated as not helpful at all.
- 1 participant indicated different sentences (no indication of length of time served), and received no support while inside.
- 1 participant spent 3 years in Trinity House and 2 years in prison - he received a detox that was rated as not helpful at all.
- 1 participant spent 1 week on remand and did not receive any support while inside.
- 1 participant served 6 months in prison, where she received a course on addiction and a detox. She rated these as not helpful at all.
- 1 participant indicated that they had spent 20 years in jail and had received a detox that was of some help.
- 1 participant had served two periods inside, one of 3.5 months and another of 6 months, had received a detox that he indicated was not helpful at all.

Physical Health

- 1 participant rated their physical health as excellent
- 3 of the participants rated, their physical health as very good.
- 16 of the participants rated their physical health as ok.
- 6 of the participants rated their physical health as bad.
- 1 of the participants rated their physical health as very bad.
- One participant disclosed a positive Hepatitis B and C status.
- One participant disclosed a positive Hepatitis C status.
- One participant did not respond to this item.
- 15 of these participants did not have a hot meal every day.
- 18 of the participants ate a lot of sweet things.
- 17 of the participants took physical exercise - this usually was walking, if the exercise was indicated. The majority of clients who responded positively to this item did not indicate the kind of exercise that they were engaged in.
- 11 of the participants took no physical exercise,

Social Supports

- 18 of those surveyed did not have many close friends.
- 10 of the participants surveyed said that they did have many close friends. 6 of those who said they had close friends commented that they were drug users. 3 of those who said they had close friends had both users and non-users in their peer circle.
- 1 of those surveyed commented that she wouldn't class drug users as real friends.
- 26 of those surveyed had close friends in the past who were not drug users.
- 25 of those surveyed currently have contact with their own family members. 17 out of these commented that their family members have problems with drugs or alcohol.
- 17 of the participants in this group were currently in a stable relationship with a partner. Out of this group of seventeen, 13 of the participants had partners who have problems with drugs or alcohol.

Drug Status

- 13 of the participants surveyed were taking a variety of drugs besides methadone. Of this 13, two did not indicate what drugs they were taking.
- Of those who did respond positively to this item, the following drugs were noted:
 - cannabis
 - sleeping tablets (not specified)
 - stilnoct
 - dalmene
 - valium
 - benzodiazapines (not prescribed)
 - heroin
- 14 of the participants surveyed were not taking any other drugs / medication beside methadone.
- One participant did not respond to this item at all.

Aspirations regarding Rehabilitation

The entire group expressed a desire to be drug-free.

PATHFINDER GROUP DEMOGRAPHIC CHARACTERISTICS

Gender

At the time of the survey there were 10 service users participating on the Pathfinder programme five male and five female.

Age

These participants are an older group. Relative to the ages of the participants surveyed in Patricks Street.

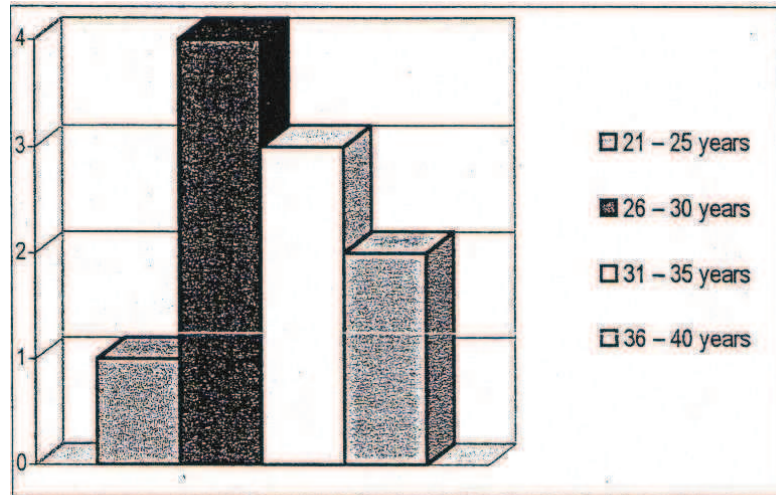


Fig. 6 - Age Profile of Pathfinder Group

Length of time attending Current Service

Seven participants are attending current service for a period of time between 6 months and one year.

Three of the participants are attending the current service for more than two years.

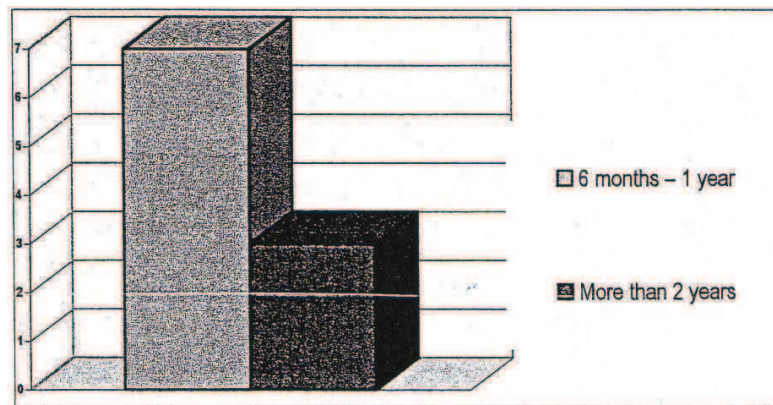


Fig. 7 – Length of time in current service - Pathfinder

Accommodation

The majority of this group are either living in the Family home or living with partner.

2 of the clients rated their accommodation as good

4 of the clients stated that their accommodation was ok

4 rated their accommodation as poor / very poor.

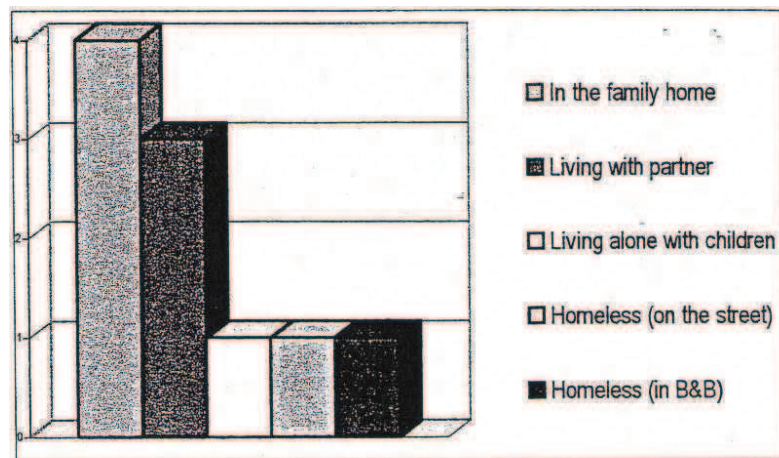


Fig. 8 – Accommodation - Pathfinder

This was for a variety of reasons -

- 1 participant had a father who was an alcoholic and three siblings using heroin, 1 participant finds the family home overcrowded, 1 participant had been waiting for a new house. This particular participant had six children some of whom were living elsewhere due to conditions of current accommodation.
- The participant resident in the B&B had been run out of her previous accommodation due to vigilante action and has to vacate the B&B from 11 am to 5 pm due to a robbery on the premises.

Education to date

One client commented that the stress of the Leaving Certificate meant that he could use and do the exams or not do the exams and stay clean. He chose not to do the examination.

One of the clients had completed an IPPA course in childcare, and a catering and computer course with FAS.

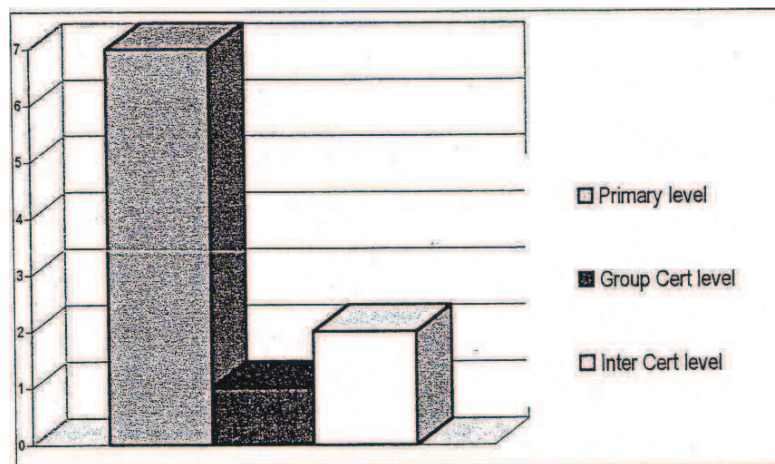


Fig. 9 – Education to date - Pathfinder

- One participant commented that he was a veteran of the CE schemes as it was the only way a disabled person could get work.
- Other courses that participants had attended include: catering, sewing, computers, first aid, woodwork, gardening and clerical skills.

Current Employment Status

- All 10 of the participants on this programme are considered to be in part-time work.
- One participant commented that he was happy with the scheme, he came on the programme 4 or 5 weeks previously. He felt the personal development component was very good. He went on to comment that the staff did not want to deal with stoned people, that there was no one listening and little imagination. He felt that the staff was thinking about 2 years down the line and not about the stage that the client was at now. He felt that work needed to be done on his self-confidence before he would be able to move forward.

Forensic History

Six of the participants had been in prison, with sentences ranging from 1 week to 12 years. It is perhaps easiest to include the client responses here:

- One participant had did not specify the amount of time spent in prison but gave the impression of having been in and out of English prisons for much of his life.
- One participant spent 12 years in prison in England.
- One participant had received various sentences of 3 months, 6 months, and 18 months but served roughly 4-5 weeks, 3 months and 9 months of each respective sentence.
- One participant stated that he had been in prison every year since 1986 for various periods of time.
- One participant served 5 weeks of an 11-month sentence and has spent days on remand.
- One participant spent just one week in prison.
- While in prison, participants received either methadone (not helpful at all), a detox (not helpful - usually because they were too short and given no other support while detoxing), were not on drugs while inside (this participant received counselling, however) or received no support while inside. One participant attended NA meetings that he found very useful and another attended yoga classes that they found to be of some help.

Physical Health

- 2 participants commented that their physical health was excellent
- 1 commented that their health was very good.
- 5 clients commented that their physical health was ok.
- 2 commented that their health was very bad.
- 1 voluntarily disclosed a Hepatitis C positive status.

- 1 voluntarily disclosed a Hepatitis A, B and C positive status.
- 9 of the participants had a hot meal every day.
- One participant went without in order to feed the children.
- 8 of the participants eat a lot of sweet things.
- All but one of those surveyed take some physical exercise, the vast majority walk. One participant weight-lifts and cycles, one participant runs and plays football, and two of the participants commented that they went swimming as part of their course.

Social Supports

- 7 of the participants did not have many close friends.
- Two of the participants who said they had close friends noted that these friends were also drug users.
- 6 of the participants had in the past friends who were not drug users. One participant commented that they still had friends who were not users, another said that the friends they had in their youth are now all dead from drugs.
- Only one of the participants had no contact their own family members. This particular participant commented that there was conflict between herself and her mother / sisters regarding her partner (also a drug user) and the living arrangements of her children.
- Of those who did have contact with their family, only three of the participants commented that none of their family members had problems with drugs or alcohol. That means of the 91 % of the participants who had contact with their family, 60% of these had a family situation characterised by multiple drug users. Typical comments include: mother and brother alcoholics, six of eight brothers have drug / alcohol problems, etc.
- 6 of the participants were in a stable relationship with a partner, Four of the partners had no problem with drugs / alcohol, two of the partners had.

Drug Status

- 7 of the participants on the Pathfinders programme were using drugs other than their methadone maintenance. This drug use includes:
 - asthma medication
 - benzodiazapines
 - cannabis
 - heroin.

Aspirations regarding Rehabilitation

All of the clients expressed aspirations towards being drug-free.

SATELLITE CLINICS DEMOGRAPHIC CHARACTERISTICS

Gender

There were 7 male and one female service users from the Satellite Clinics that responded to the survey.

Age

The majority of the service users attending Satellite Clinics that responded to survey are over 26 years of age.

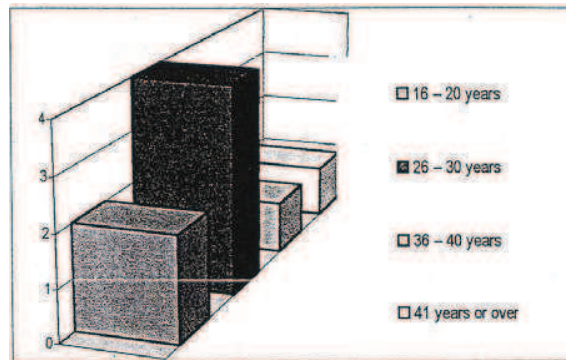


Fig 10. – Age Profile – Satellite Clinic

Length of time attending Current Service

The majority of the participants have been attending the satellite clinics for a period greater than 6 months.

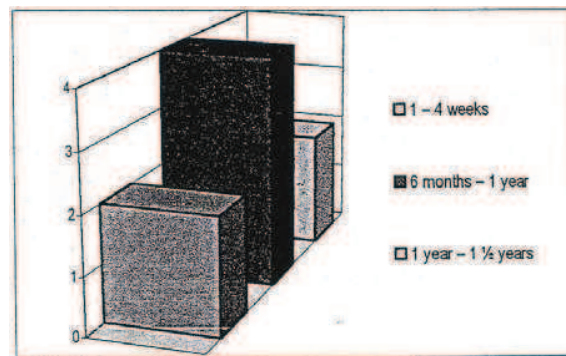


Fig 11. – Length of time attending Clinic

Accommodation

One of the clients commented that they were in a temporary living situation at the moment.

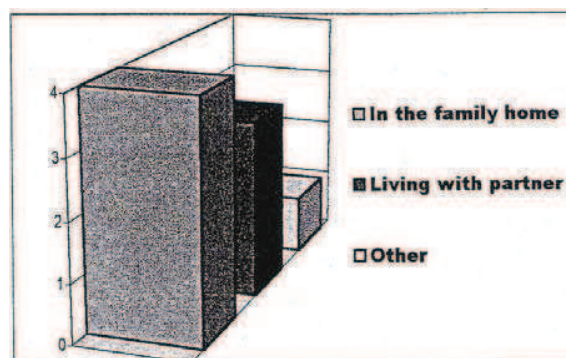


Figure 12. **Accommodation** – Satellite Clinic

Education to date

3 of these clients had attended a FAS course in a variety of disciplines - computers, gardening, personal development, construction, etc.

One of the clients had an NCVA qualification in computers.

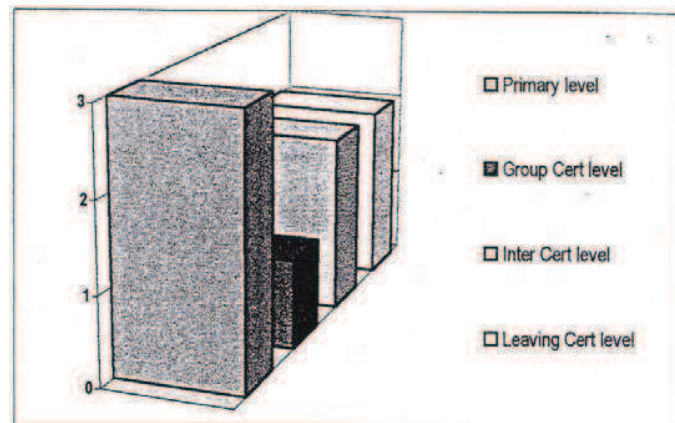


Fig 13 - Education to date - Satellite Clinic

Current Employment Status

4 of the participants indicated that they were happy with their employment

1 client was not satisfied, saying that he worked very long hours for very little pay.

1 of the clients did not indicate either

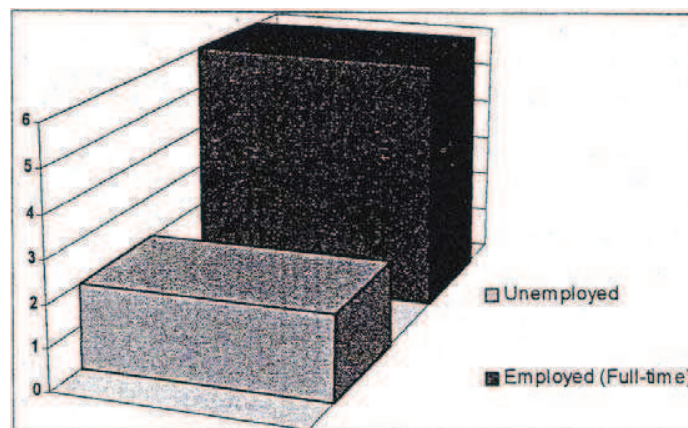


Fig 14. - Current Employment Status - Satellite Clinic

- 4 of the participants indicated that they were happy with their employment
- 1 client was not satisfied, saying that he worked very long hours for very little pay,
- 1 of the clients did not indicate either satisfaction or dissatisfaction.

Forensic History

- Four of the participants had not been in prison.
- The other four participants had been in prison for the following sentences:
 - Various periods (6 month sentences to 2 year sentences). This participant received a detox but no maintenance, which was of some help.
 - 3 months. This participant did not receive any support while inside.
 - 12 months. This participant was not on drugs while in prison.
 - 5-6 years. This participant received a detox, which was of some help.

Physical Health

- 2 of the participants said their physical health was excellent
- 1 of the participants said their health was very good.
- 2 of the participants said their health was ok.
- 3 of the participants said their health was bad.
- All 8 of the participants had a hot meal everyday.
- 6 of the participants commented that they ate a lot of sweet things.
- 4 of the participants took no physical exercise.
- The other 4 participants engaged mainly in walking, although one client went weight training every second day.

Social Supports

- 5 of the participants said they had no close friends.
- Of the three who did have close friends, these friends were also drug users.
- Only one of the participants did not have friends in the past who were not drug users.
- 6 of the participants had contact with their own family members. Five of the eight clients came from families where there were other drug users.
- Four of the participants were in a stable relationship with someone at the present time. Of this four, three of the participants had partners who had problems with drugs or alcohol.

Drug Status

- Four of the participants were not using any other drugs besides their methadone.
- Of the four who were using, one did not specify what drugs / medication he was on. The other clients were taking a variety of drugs - benzodiazepines, rohypnol, cannabis, viagra and valium.

Aspirations regarding Rehabilitation

- All but one of the participants aspired to be drug-free in the future.
- 1 of the participants believed this to be impossible for him.

GP CASELOAD DEMOGRAPHIC CHARACTERISTICS

Gender

There were 10 male and 1 female service users that participated in the survey.

Age

The majority of the service users attending GP's that responded to survey are over 31 years of age.

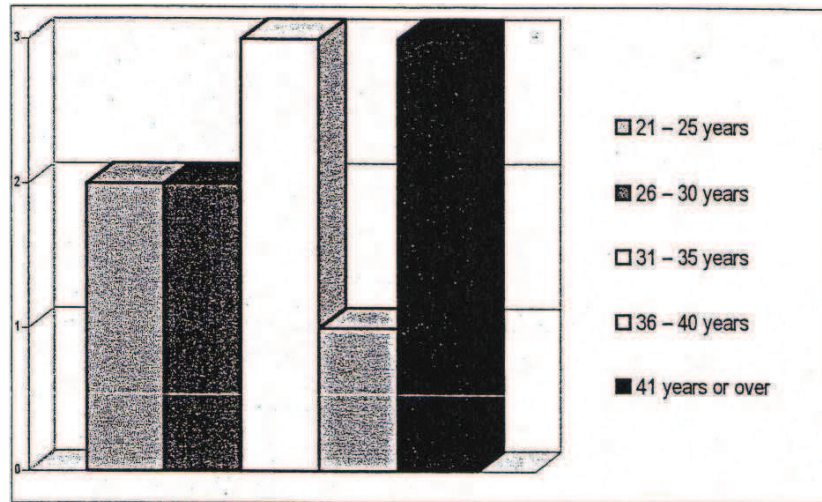


Fig 15 - Age - GP Caseload

Length of time attending Current Service

There are almost an equal number of service users with GP's for a period under 1 year as there are service users for a period greater than this.

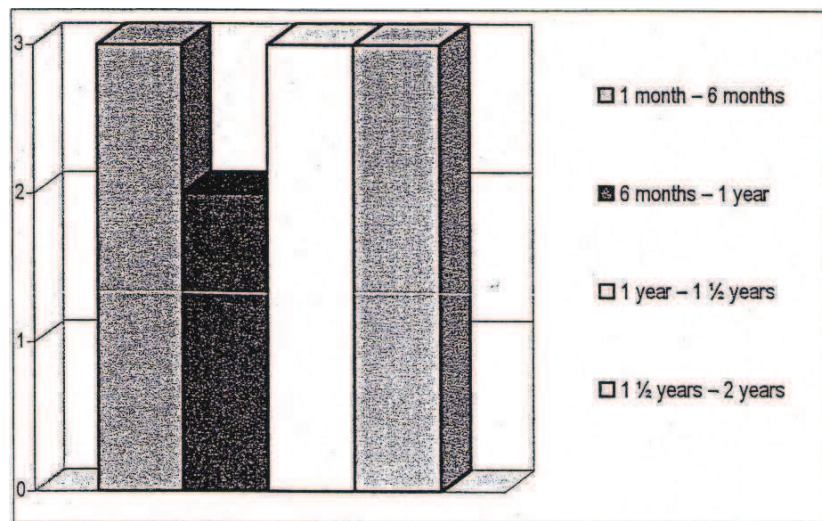


Fig 16 - Length of time attending Current Service- GP Caseload

Accommodation

Only 1 person surveyed indicated that they were homeless - living in a B&B.

The majority are either living with a partner or living at home.

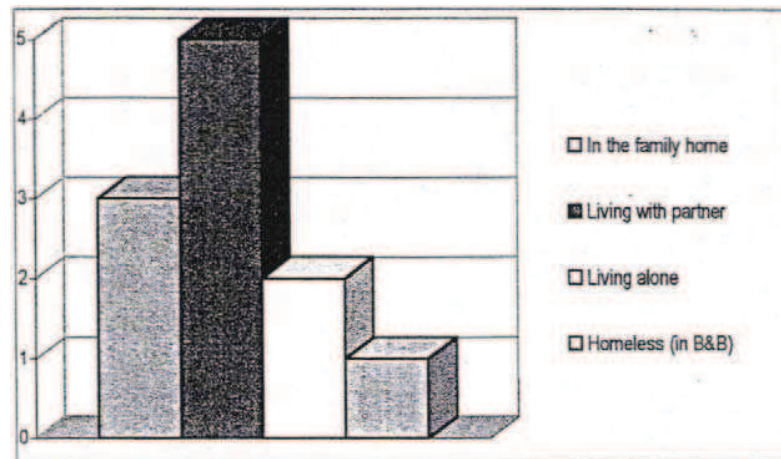


Fig 17 – Accommodation - GP Caseload

- 2 participants rated their accommodation as excellent.
- 5 participants rated their accommodation as good.
- 3 participants rated their accommodation as ok.
- Only one client commented that he were in a “dodgy situation” as regards accommodation, due to conflict with family.

Education to date

1 of these clients had completed his BSc in Trinity College Dublin while on a methadone maintenance programme.

6 of these clients had completed FAS courses (computers, forklift operation etc)

1 had received on-the-job training

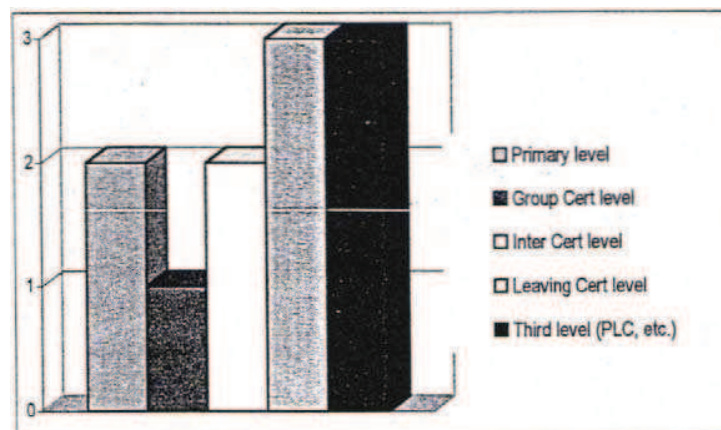


Fig 18 – Education to date - GP Caseload

1 participated in the work incentive scheme.

4 of these clients had not taken part in any FAS / CERT courses.

Current Employment Status

- Only one of the service users in this category is unemployed, the rest are employed in a full-time capacity.
- of the clients surveyed were satisfied with their jobs, with job dissatisfaction being expressed by only 1 client.

Forensic History

- Nine of the participants had not spent any time in prison.
- One of the participants was on remand in Mountjoy for one week, and received methadone while inside. He believed this was of some help to him.
- One participant was in prison for six months, where he received a two-week detox. He rated this as not helpful at all.

Physical Health

- 5 participants rated their physical health as very good
- 5 participants rated their physical health as ok
- 1 participant rated their physical health as bad. This client voluntarily disclosed his Hepatitis C positive status.
- All of these participants had a hot meal every day.
- 6 of these participants did not eat a lot of sweet things. 5 of the clients ate a lot of sweet things.
- 7 of the clients took physical exercise - either walking, kick-boxing, playing football, weight-training or attending the gym.
- 5 of the clients took no physical exercise.

Social Supports

- 6 of the clients surveyed said that they did not have many close friends.
- 3 of those who said they had close friends commented that they were drug users.
- Only 2 of those surveyed had close friends who were not users. 1
- 10 of those surveyed had close friends in the past who were not drug users.

- 10 of those surveyed currently have contact with their own family members. 3 out of these ten commented that their family members have problems with drugs or alcohol.
- 9 of the clients in this group were currently in a stable relationship with a partner. Out of this group of nine, 2 of the clients had partners who have problems with drugs or alcohol.

Drug Status

- 6 of the clients surveyed were not taking any other medication besides methadone.
- 5 of the clients were taking valium, anti-depressants or cannabis.

Aspirations regarding Rehabilitation

The entire group expressed a desire to be drug-free.

VIEWS ON REHABILITATION

Factors helping clients cope with their drug use

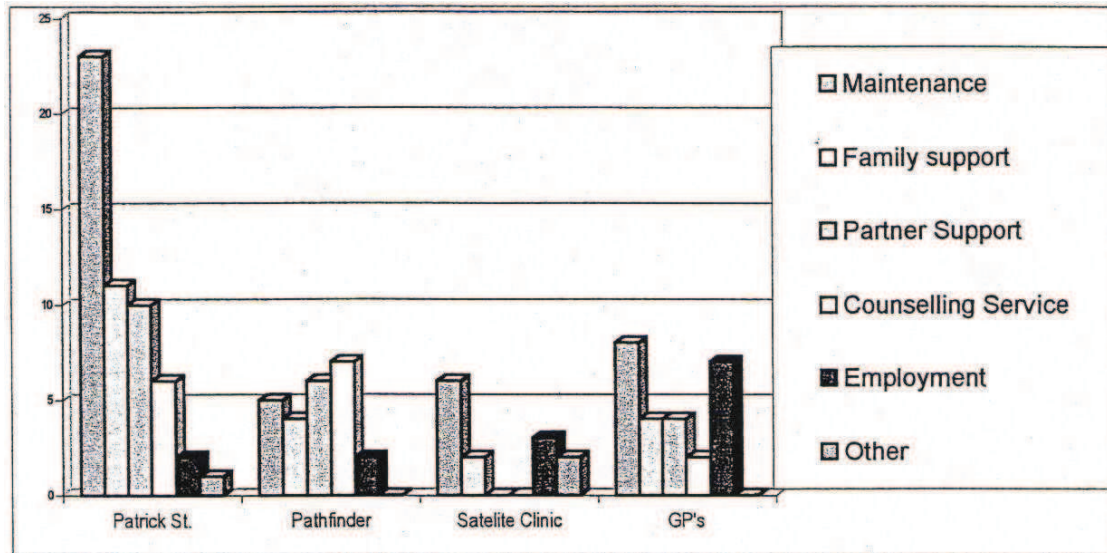


Fig 19 – Factors helping clients cope with their drug use

This section stimulated a variety of insights into both aids and barriers in rehabilitation. For example, one of the participants attending the clinic in Patricks Street commented in this section that she was attending counselling but after 3 weeks her counsellor left, another commented in this section that he was in Coolmine and the counselling there was very good. In relation to this point about counselling, a participant on the Pathfinders scheme commented at this point that he was receiving counselling more suitable for an alcoholic and that he could not be completely honest in counselling sessions for fear of repercussions. Another participant commented at this point that he feels that he cannot confide in anyone. His counsellor left at some point previously, and this has happened twice before. He stated that he got the attitude of “I’ve heard that one before” from the new counsellor.

The Pathfinder participants did, however, indicated other factors helping them cope with their drug use. One stated that the support of the probation service had helped and another specifically referred to participation on the Pathfinders scheme. It is interesting to note that three of the clients (ail on the Pathfinders project) were vehemently opposed to the maintenance programme, commenting that:

- Methadone is too freely given out
- Methadone may be necessary to function but it is more damaging then heroin
- Methadone is extremely dangerous

In terms of family support, one participant commented that her parents don’t know about her current situation and another stated that they had been addicted to gambling prior to becoming addicting to drugs. He said that being bailed out by his family during this time was a drawback in terms of recovery and he favoured tough love methods. One participant from Patricks Street stated that the access that he had to his two-year-old daughter was a significant factor helping him cope with his drug use.

Finally, 2 satellite clinic participants commented that (a) they were open to suggestion (as to what exactly was helping them cope) and (b) one was on a detox currently so felt unable to comment.

Barriers in getting over drug problem

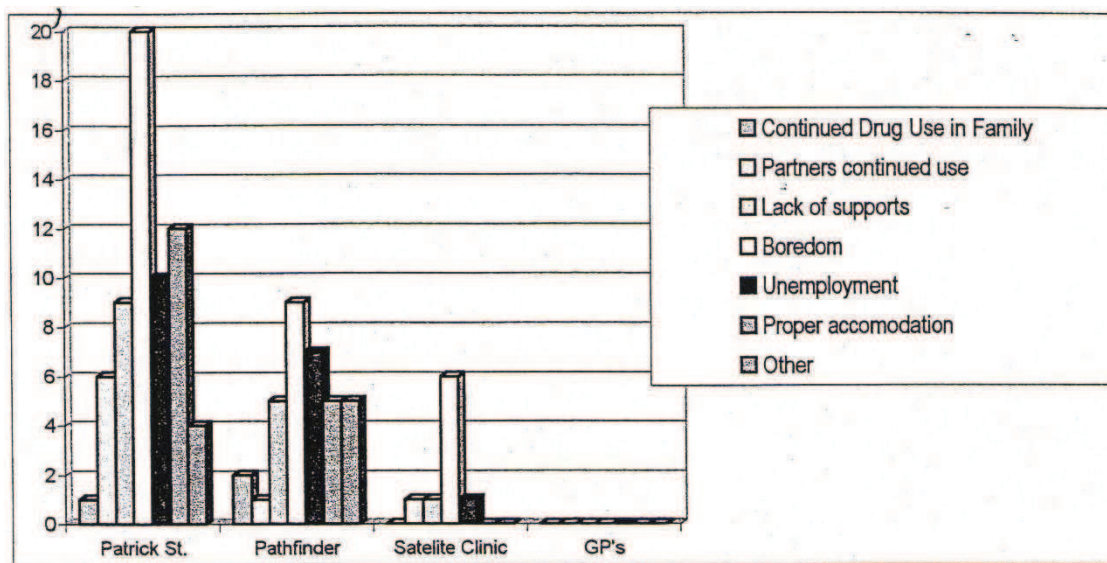


Fig 20 – Barriers in getting over drug problem

Both the Patrick Street clinic and the Pathfinders participants identified other barriers in getting over their drug problem. These include:

- their friends continuing to use
- their “moods”
- the continued availability of drugs
- lack of self-confidence
- other people on the scheme not being stable enough to participate on the scheme
- the counselling within the scheme
- lack of direction within the service.

Two participants indicated that their personal circumstances were barriers - e.g. one participant can't work as he is attending clinic in the morning, another stated his brother is still using and dealing

One of the Pathfinders commented on the *“methadone bankroll”* in this section, suggesting that the maintenance programme was not based around client needs.

Important factors in helping clients stop using

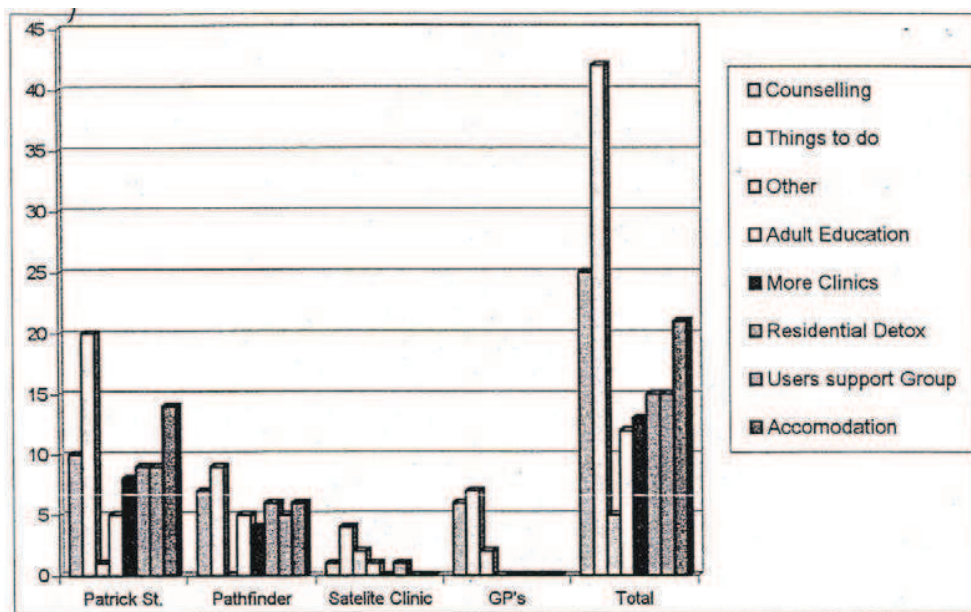


Fig 21 – Important factors in helping clients stop using

Some of the items above were agreed with but qualified by the participants. In other words, one participant said that things to do would be important, but only for people who wanted them. One participant in the satellite clinics indicated a residential detox. This person qualified this by saying that they would like a detox but couldn't avail of a residential programme as they would lose their job otherwise. Another satellite clinic participant indicated a residential without a detox - obviously indicating a desire to be removed from his immediate environment.

The only other factor in helping clients to stop using was employment and three participants indicated this.

It should be noted that 4 of the Pathfinders participants commented that:

- clinics were being abused
- people are at different stages of rehabilitation, smaller clinics with people at different stages attending on the same days would be better
- clinics were places where you had to mix with people who were stoned
- clinics were being abused with people attending with dirty urines – detox initially is better

5 of the Pathfinders participants were in favour of a user support group, with one qualifying that statement by adding that the group would need to be away from the clinic" there would be no discomfort around the sharing of information. One of the clients who did not indicate a users support group as a positive thing said that it would just be a further temptation for him.

One of the GP caseload participants stated that only he could help himself stop taking drugs. This could be a common feature of this group, as in informal conversation with a number of participants after administering the questionnaire similar statements were made by others.

Supports needed for a better lifestyle

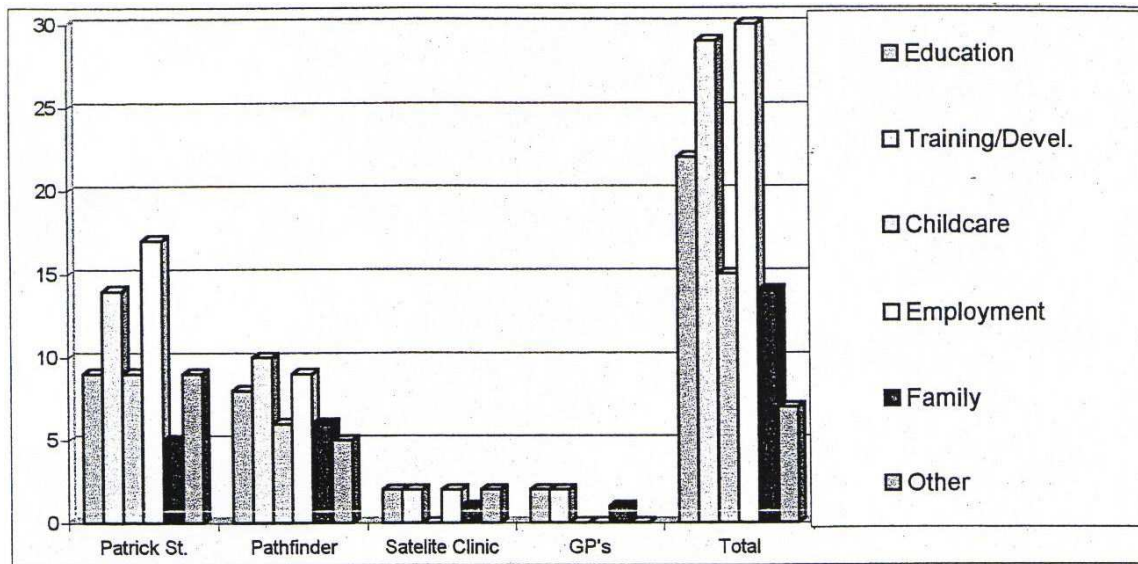


Fig 22 – Supports needed for a better lifestyle

Again, the items in this section were agreed with but qualified in some cases by the participants. For example, one participant stated that education would be of the greatest benefit after 1 year, when there was greater stability. Another requested that training be vocationally based.

Other supports indicated by participants include: accommodation support, drug awareness, information about long-term damage, separate support for families from clinics, more counselling, more exercise, and a greater focus on activity. One of the clients felt that ways of meeting people who were not in a similar situation would be ideal, as the social isolation felt by drug users was a contributing factor in their relapse. She felt that there weren't many ways of forming a social structure, owing to a previous status as an active drug user.

Prior Attendance on a Rehabilitation Course

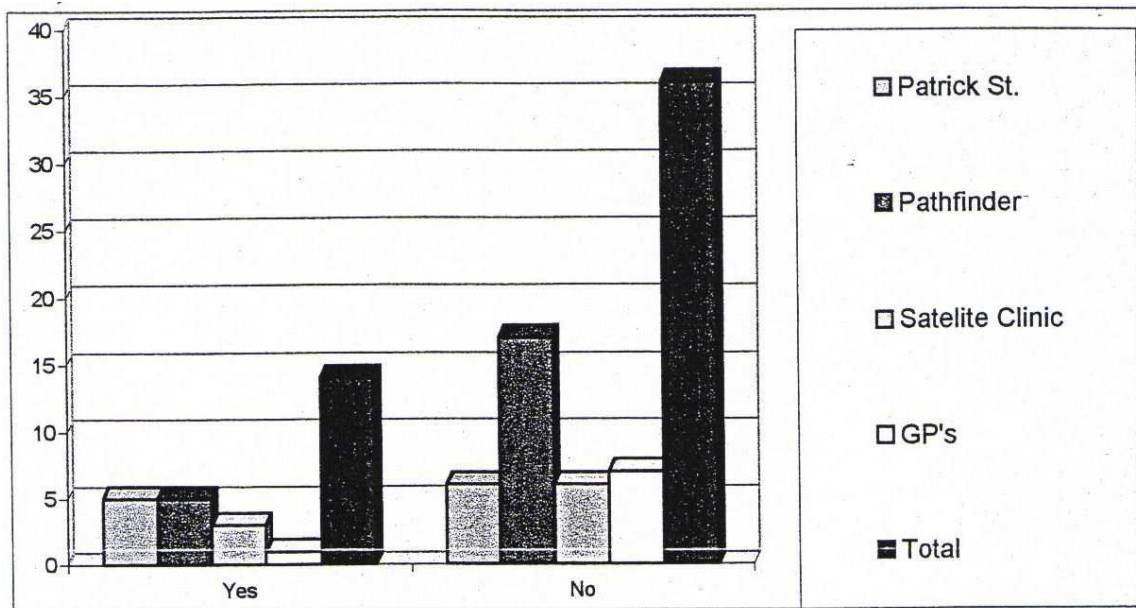


Fig 23 – Prior Attendance on a Rehabilitation Course

One of the participants who indicated they had not attended a rehabilitation programme because they weren't any. One participant did not indicate which service he had attended but had found it useful: he did not indicate why. Two participants had attended Coolmine and found it useful, while another felt that his rehabilitation was not successful in Coolmine as he was taken out of the environment where he had begun and maintained his drug use. Four participants had attended in Beaumont and found it useful - one commented that he was drug-free for seven months after this attendance.

One participant attended a rehabilitation programme in New Zealand where he received counselling that he found to be particularly beneficial. One client had attended Soilse, which was found to be useful as it kept the participant busy and the other participants and staff were helpful. One participant had received a ten-day detox that was indicated as useful but no reason for this was given. Finally, one participant had attended the Rutland Service, Cuan Dara, Sister Consillios and a residential in Donegal.

Two had attended the service in Jervis Street, with one expressing dissatisfaction with the level of service that he received there. He said that personal conflicts jeopardised his rehabilitation while attending. Three participants had attended rehabilitation programmes and not found them to be useful - one said that he spent 10 days incommunicado and going cold turkey and suffered extreme paranoia and homesickness while there. Another client commented that residential programmes were ineffective, in that the programme may have been useful but once he got out he went using again with "the lads".

Desire to attend a rehabilitation course in the future

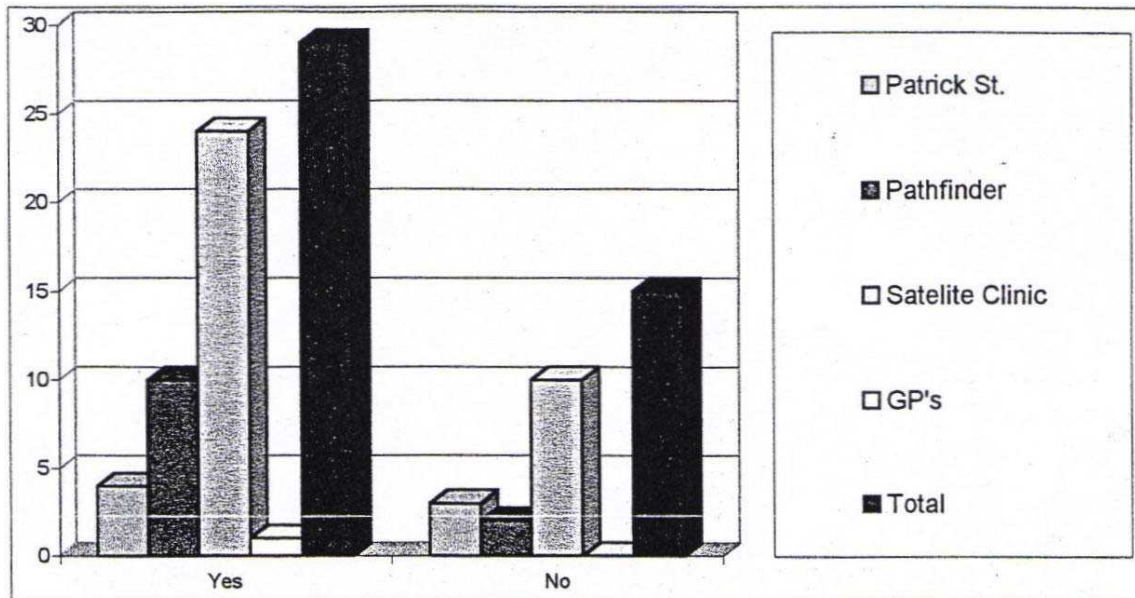


Fig 24 – Desire to attend a rehabilitation course in the future

Of those who wished to attend a rehabilitation course in the future, a variety of reasons were given. These include: it would be a good thing, to see what it was like, to meet different people, to help find better work, to do something better with my time, it has to be better than nothing, and to fill up the day.

All of the pathfinders expressed a desire to attend a rehabilitation course in the future and this group made the following comments alongside this item:

- One participant said that they would be interested.
- One participant said that such a programme would be very beneficial in helping him off drugs.
- One participant suggested modules in desktop publishing, parenting and home management as part of such a rehabilitation programme.
- One participant included crèche facilities as a component of such a rehabilitation programme.
- One participant suggested inviting guest speakers to the rehabilitation programme.

Of those who did not want to attend a rehabilitation course in the future, the primary reason given was that they were already in full-time employment. Others did not give a reason or made one of the following responses: only wanted vocational training, were too old to avail of such a service or did not believe in such course.

Any Other Comments (Patricks Street)

- 13 participants did not indicate anything in this section.
- 1 participant entered “needle exchange” into the comment **box**.
- 1 client put “do something about if in the comments box.
- 1 participant stated that “no help given”.
- 1 participant said, I think there should be at least one Drop-in centre with proper counselling and a job search programme. The clinic is very good, the staff are very helpful but the people need more information on what’s available.
- 1 participant commented that “more support for family who have little contact with their kids and more help with kids in a lot of matters”,
- Other comments made include:
 - The social exclusion of every day life is hard to bear, the hiding of everything like the clinics and the methadone, in the chemists make you feel like a social misfit and a criminal.
 - Drugs are a way of life - when you give up the drug you need to find a new way of life and things to fill it This is usually very difficult to do.
 - I think the services in this clinic have improved greatly since it began in 1997.
 - I think it is hard to get people to help you to get into treatment. It should be a lot easier.
 - There should be a needle exchange for the other people (like kids on drugs).
 - People are not encouraged to work when attending daily. There is a catch 22 situation as well, as people are too sick without methadone and work is therefore impossible on this programme.
 - A similar to project to Merchants Quay is needed in Dun Laoghaire and more emphasis on counselling is necessary. This client told the researcher that he has attempted suicide but is getting no counselling.
 - I would like to change clinic, as I am homeless and have to come to Dun Laoghaire everyday and live in town in a B&B.

Any Other Comments (Pathfinders)

- Three of the clients stated a needle exchange was necessary for the Dun Laoghaire Rathdown area.
- One of the clients stated that there should be more activities for teenagers (especially after school) as a preventative strategy.
- The other clients had a variety of comments including:
 - You received more help when you have made a mistake, which perhaps you wouldn't make a mistake if the service provided were more proactive. He stated that the right help is essential and was suspicious about the idea of group therapy. He stated that the addict during withdrawal is paranoid and feels like they are in a shell - trust is a very tenuous thing.
 - Clients need help with counselling now - they cannot afford private counselling. This participant was involved in the patients charter which was submitted to the relevant authorities - he received no feedback and is consequently very apathetic. He feels that his opinions are not taken on board.
 - The hostility from the public was very damaging. This client admits to having dealt drugs but says there is no evidence of this. Her status as an addict is well known, however, and she has been refused entry to most establishments because of this. She had moved constantly from area to area and her son has missed a total of 7 months of school and has been kept back.
 - One client stated that she were very interested in Pathfinders. She requested a talk on Hepatitis C she is Hep C positive and does not know anything about the disease. This client lost some benefits after attending Pathfinders, despite being told otherwise. She would like more information on entitlements, especially social welfare.
 - There aren't enough counsellors and the existing service is over-stretched. They are too busy to be effective, counsellors don't remember previous sessions, there is no continuity between sessions and the clients see no benefits. This client stated that clinic should be completely separate agencies, but have a liaison counsellor to refer clients to counselling if necessary. There was a certain amount of embarrassment at having to attend the clinic on Patrick Street due to the anti-social behaviour of some of the other attendees. The client believed that there should be more communication and said that he is sick of being told "no". He also expressed some frustration and resentment at the current situation.

Any Other Comments (Satellite Clinics)

A variety of comments were made:

- 1 participant stated that he was happy enough with the service that he was receiving at the moment. He finds it difficult to cope with his partner's use. There are warrants out for this participant's arrest and he will be going back to prison soon. He commented that he does not use in prison because of dirty works, etc. He finds the fact that others using around him difficult and the awareness of the prison officers of what is happening and the concurrent lack of action disheartening.
- 1 participant stated that he would like to see a regional rehabilitation facility in the Dundrum area where people "on the same buzz could go on the same day"; i.e. if you are stable you go on one day, if you're chaotic you go on another.
- 1 participant stated that juggling employment and getting to the chemist was difficult.
- 1 participant was happy with the service on offer, he likes the freedom of being able to work. He did find having to be at the chemist and the clinic difficult, especially with the demands of his employment.
- 1 participant was very afraid of neighbours / daughter finding out that he was a user. He felt that all the trust would be gone and that he would be subjected to discrimination. He also found it difficult to juggle his work commitments and attendance at the clinic and chemist.
- One client was happy overall with the service being provided, although found the waiting list long.

Any Other Comments (GP Caseload)

No other comments were made by any of the clients in this group.

IMPLICATIONS FOR REHABILITATION

Gender

It is interesting to note that none of the participants attending the Oasis project or the Pathfinders scheme mentioned any gender based conflict/problems. In fact, the participants on the former were explicit in stating their positive experience of a mixed gender grouping. There are no clear-cut implications for rehabilitation here, other than the very presence of women on any future programmes usually indicates childcare facilities will be needed as standard.

Age

There is an age variance in each of the groups and this may need to be borne in mind for future rehabilitation, in the sense that a very young or very old client (relative to others in the group) may feel isolated or a lack of peer support. It has to be stated that one participant in the GP caseload felt that he would have liked to attend a future rehabilitation programme but he felt too old. It should also be noted that certain GPs have recognised young drug users as being a high risk group, and that early interventions in this group are efficacious. As such, age differentials do have a part to play in the success of future rehabilitation,

It is incumbent on the service providers to manage this possible problem as proactively as possible. Older clients could be encouraged to act as mentors for the younger group, for example, or clients of similar ages could be grouped for certain activities. It is important to act as sensitively as possible in this regard and judge each situation on its merits.

Length of time attending current service

It must be recognised that there are significant numbers moving through the clinic in Patrick's Street. This may warrant further research to determine exactly where these clients are going. Are they progressing on to a satellite clinic / GP surgery or descending into chaotic drug use and not availing of any service? As can be identified quite clearly, all of the participants from the Pathfinders group have been attending this service for longer than 6 months. With respect to the other programmes currently in place, a little over half have been attending in the last six months.

It has to be said that the length of time attending the current service may have implications for the client rehabilitation. Clients who have been attending the Patrick's Street service, for example, for 4 weeks are attending the same clinic that other clients have been attending for over 2 years. This may indicate different Kinds of drug users - those who move swiftly through the system and those who become static at a certain point. Difficulties can arise for both groups. Of clients -the newcomers may become negative about the service and thinking that they will never leave, the more established attendees may see themselves as failures in terms of rehabilitation. This is especially so when they are seeing new clients coming to the clinic and they themselves have not progressed any further.

There can be a similar experience for Pathfinders clients as the one indicated above. The fact that new clients coming onto this programme may easily identify those who have been there for 2 years can lead to a sense of resentment in this group, as they may wonder or become frustrated as to why there are people on the same programme for two years. It also can be difficult for this new client to break into the established social order, leading to a sense of isolation on their part. At the same time, the clients who have been attending the service for

lengthier periods may become frustrated with what could easily be perceived as their lack of rehabilitation success. It can also be upsetting for established group members to have to share personal and painful experiences with newcomers. Alternatively, one has to recognise the view expressed by some researchers that it is easier to establish a “buddy system” within such a set-up, as established members can take a newcomer under their wing, so to speak. This can ease the transition for all concerned, provided it is well planned and resourced.

Of course, these feelings of failure are purely speculative and no client was asked whether they felt negative about rehabilitation or whether they felt they were failures. This can be qualified by comments made by several clients at the satellite clinics and at GP surgeries. These clients stated that they were very happy to leave Patricks Street as they felt they were progressing in their rehabilitation and they were no longer surrounded by a hard-core group of drug users who constantly slipped from some form of stability to chaos.

Accommodation

The majority of the entire sample live in their family home - “family” referring to their family of origin. (This item did cause some confusion amongst some clients, however, as they were unsure whether family home related to their family of origin or the family that they had established with their partner and / or children.) It follows from the above that rehabilitation that considers the client in isolation is not accepting the reality of the kinds of situations that clients are in.

Dornan (1999) commented that nearly 60% (of the sample from his study) who were living in the family home were dissatisfied with their accommodation, mostly due to tensions and overcrowding. In contrast, very few of the clients in Dun Laoghaire Rathdown volunteered information relating to tensions in the family home, and none explicitly stated tension / overcrowding as a reason why they were dissatisfied with their accommodation.

There were a significant proportion of clients who expressed dissatisfaction with their accommodation. The unenviable conditions of some of the clients are blatantly obvious from the comments made by those who are homeless,

The implications for rehabilitation concur with other similar research - without proper adequate accommodation clients will be unable to engage in a positive recovery. It is recommended that some form of closer communication / liaison takes place between the local authority housing officers and rehabilitation agencies in Dun Laoghaire Rathdown.

Education

The impact of the growing importance of educational qualifications has been particularly significant for the group of young people who leave school without any qualifications (McCormack & Archer, 1998). This can be seen in a comparison of the 1991 and 1996 school leaver surveys (Department of Enterprise and Employment, 1993; Williams and Collins, 1997). In 1991 the employment rate for those without qualifications was about 50%. By 1996 the unemployment rate for this group was nearly 70%.

The education level of the Patricks Street group is particularly low. The clients in Patricks Street had the lowest level of achievement in formal schooling. A full 22 of the clients left school after the Group / Intermediate / Junior Certificate and there was no indication of whether there was attainment of the relevant certification. This gives the startling figure of 78.5% having left school

Page 41 missing

Employment

Fitzgerald (1998) comments that a Labour Force Survey indicates the percentage of male unemployment in 1994 as roughly between 15 - 25 %, depending on the age of the participant. Thornhill (1998) quotes an OECD survey that sets unemployment rates by level of educational attainment. The rate of unemployment of the group whose level of education was below upper secondary level was 16.4%. In contrast to these national figures, the current unemployment rate of the clients in Dun Laoghaire Rathdown is roughly 53.1%. (Rate ascertained by discounting the clients attending the Pathfinders and Oasis schemes and dividing the remaining sample into the number unemployed.)

As can be seen clearly in the above data, the vast majority of the clients in Patricks Street are unemployed. Just as contrasts could be observed between users in terms of educational status, so too can the same kinds of differences be observed in terms of employment status. .03% of the Patricks Street clinic group are in full-time employment, as compared to the 90.9% of the GP caseload. 14.3% of the Patrick Street cohort do have some meaningful activity to engage in, whether that is full-time / part-time work or participation on a scheme. There is a massive 85.7% without such activity.

In terms of rehabilitation, it needs to be emphasised that this is not an unexpected finding. The clients in the Patrick's Street group appear to be in a very precarious stage of recovery and are, relative to the others, the more chaotic group. What should be pointed out is that eventually this group will be in a more receptive state to receive some form of further education or vocational training. Rehabilitation programmes in the future will need to take into account that those who have reached a fairly stable stage in recovery will be looking forward to the future and will need some form of employment support.

Boldt (1997) notes that sample populations with difficulties with literacy and numeracy and low self-esteem seemed to correspond strongly with unfavourable labour market experiences. Furthermore, skills related to searching for jobs, filling in applications and interviewing appeared to be lacking amongst such samples (Boldt, 1997). The clients surveyed across services in Dun Laoghaire Rathdown are such a sample population. It is therefore recommended that a sheltered employment initiative be established as a final phase of recovery for recovering users. Clients would benefit enormously in a number of ways and competencies of the sort outlined by Boldt and others would be developed in a supportive atmosphere that was threat-free and safe for the client. Supported employment would have the additional advantage of making the client an attractive potential employee, while instilling confidence to seek employment.

Anecdotal evidence would suggest that rehabilitation programmes are most successful when run as a scheme, where clients are receiving payment. The positive attitudes of the Oasis participants towards their attendance on the scheme are an example of this. There are myriad possible reasons for programme being more successful when participants are paid, all of which necessitate further research. These reasons may include: the boost to self-confidence in terms of "coming off the dole", the increase in self-esteem and self-worth through participating in meaningful engagements during the day and the practical benefits to being so engaged.

A cautionary note must be sounded about rehabilitation programmes that offer payment. Many clients are eager to attend these schemes and may over-estimate their capability of participation. When these clients have to cope with the kinds of stressors associated with attendance on such a scheme, the possibility is there that they will cope with this stress in the

form most habitual to them - returning to drug use. The risk that others on the programme would then themselves become destabilised (as a result of another's use) must also be considered. It is not just their stabilisation that is at risk, however. Their levels of trust in the service providers' ability to maintain a safe environment can also be threatened.

A possible remedy for this situation is stringent assessment of clients who wish to attend any future rehabilitation programmes. This assessment must necessarily include input from all of the services that the client is availing of, and must not rely solely on the opinion of one or two individuals. Many rehabilitation programmes have forms of assessment already in place, and liaising with the agencies providing these programmes to examine the efficacy of assessment would be worthwhile.

Forensic History

Exactly half (50%) of the Patrick's Street cohort has been in prison. This indicates a need for a formalised communication and possible link-up between the rehabilitation providers and the probation service. There appears to be a disparate number of Pathfinders participants in terms of forensic history, relative to the satellite clinics and to the GP caseload. 60% of these clients have spent time in prison, as compared to 50% of the clients in the satellite clinics and 18% of the GP caseload.

Clients who are leaving the prison system and trying to rehabilitate themselves with the aid of statutory / voluntary agencies can only benefit from such an input from the probation service. Indeed, one of the Pathfinders participants specifically mentioned the probation service as a positive aid in their recovery. Support for the development of multi-disciplinary teams to develop integrated and holistic care, and for the need regarding more structured linkages between specific programmes and the prison services have already been recognised (External Review of Drug Services for the EHB, 2000).

The kinds of support that clients have received in prison can have implications, especially when the client feels they did not gain from this support. They can be suspicious when offered the same (as they perceive it) service on the outside. There may be possible frustration and resentment on their part that they are being offered a service they feel is of no use to them.

For those who have spent time in the prison system, it has to be stated that there is a huge variation in the sentences served. Someone who has spent 1 week on remand cannot have the same perspective / life experience as someone who has spent 23 years inside. This information acts as a caution to service providers - just because many clients indicate that they have a forensic history does not necessarily mean that each of these clients can be treated in the same way. This consideration is necessary purely in terms of the coherence and stability of the group and the dynamic between group members.

A further issue that must be considered (brought to the attention of the researchers by the GPs) is the provision of methadone in prisons (and psychiatric hospitals). It is only under certain conditions that clients receive methadone either in prison or in psychiatric hospitals. Obviously, clients are interacting with the prison system and some clients have been admitted to psychiatric hospital from Patrick's Street. It has been highlighted by the GPs that the discontinuation of maintenance in these locations is detrimental. The recommendation would therefore be that links with the prison service be utilised to propose the continuation of this treatment.

Physical Status

Please note that much of the commentary and recommendations in this section arose from discussions, etc. with Dr. Maloney in Patrick's Street His contribution was invaluable in making realistic conclusions about the data collected from clients.

77.1 % of the main survey rated their physical health as being either ok, very good or excellent Few clients volunteered a positive Hepatitis A, B or C status - Hepatitis C was the most common of the three. It has to be noted that this appears to be a gross over-estimation of the reality. GPs report that levels of Hepatitis C are reaching approximately 90% in Patrick's Street alone. Treatment for this disease is available and dramatically reduces chances of contracting cirrhosis of the liver and other serious liver diseases later in life. It is unfortunate that this treatment can cause flu like symptoms that clients may confuse with withdrawals.

The GPs in Patrick's Street have themselves established a link with the local hospitals, and a small number of carefully selected clients are attending the Hepatology Unit for treatment It is recommended that such an innovation be acknowledged and fully supported in any way possible. It is further recommended that health education modules be compulsory for any participants on future programmes. It has come to light from the survey that some of the clients are not precisely clear on what Hepatitis C is and the kinds of behaviours that they can engage in for their overall health promotion.

The number of clients not having a hot meal everyday is highest in Patrick's Street This further contributes to the overall picture of the clients there being the least stable of the groups. Diet and nutrition will play an ancillary role in providing a holistic service to clients, and modules on any future programmes could explore areas such as dental care, healthy eating, exercise and cooking on a budget.

There are a high percentage of participants using other drugs along with methadone. This has implications for the individual's rehabilitation. Workers on a rehabilitation programme may not be fully prepared to meet the needs of poly drug users, even in terms of not knowing what to expect from such a client. The psychopharmacological effects of such drug use may cause changes in cognition, behaviour and affect and obviously workers need to be made aware of this. A far more pertinent implication is the destabilising nature of drug use outside the maintenance programme. Some clients on the programme may return to using chaotically, other clients may resent and be frustrated with this individual.

Chaotic heroin use cannot therefore be tolerated on a stabilisation programme. It has to be noted that any return to poly drug use cannot be assessed on urine analysis alone. Instead, the level of use and the overall clinical assessment needs to be considered. To this end, the inclusion of the GP service in the implementation and maintenance of any future rehabilitation programme is vital. It is also important that links between the clinic and the rehabilitation programme go both ways, in that clients who are de-stabilising on the rehabilitation programme can be linked back in immediately with the clinic.

The GP service also highlighted a number of areas where service provision is either lacking or under-resourced.

- The first of these is services for pregnant women who are drug users. It was noted that the primary need here was for accommodation. It has been suggested that a link could be made with women's groups / women's refuges in the area, or that alternative

provisions could be made. The women are also in need of medical assistance, and they do not tend to make full use of the antenatal service. The GPs are already in place and willing to do something to remedy this situation but further support needs to be given.

- A second service that needs to be re-evaluated is the management of AIDS. The GPs have noted that not all of the patients travel to St. James' Hospital to receive treatment. The doctors have recommended that a formal liaison with St James' be established -perhaps including the provision of a Health Board bus to increase attendance. Again, acknowledgement and support for these innovations needs to be given and communication regarding these issues needs to increase.
- A third area that also needs to be examined is the risk of cervical cancer in the client group. The GPs have recommended that cervical screening should begin in the clinic. This report would further recommend that awareness campaign be mounted within the client group to raise consciousness about these kinds of health issues.
- Finally, the denial service for clients is poorly accessed - largely because of difficulties in obtaining a medical card. Clients have indicated (not in this research but directly to the GPs) that the process for application for the medical cards is extremely user-unfriendly. The current service could therefore be expanded to include someone at the clinics who would aid in the completion of forms, etc. In relation to dental health, the GPs have recommended that consideration be given to the provision of dental services onsite in the clinics.

Social Supports

The majority of this group have no close friends or whose only friends are fellow drug users. The fact that 92.3% of clients had friends in the past who were not drug users indicates a massive loss of peer support.

Rehabilitation could therefore do well to include some form of life skills / social skills training. Instruction could be formal or informal, or even demonstrated through modelling. This will aid clients in renewing / forming friendships. The modelling could easily take the form of a buddy system, where more established members of the programme take a newcomer "under their wing". Alternatively, the incoming participant could nominate a friend / family member to be their carer during their time as a member of the programme.

The high levels of drug use within the family are also significant, especially considering that the majority of the clients are actually living at home. It is interesting to note that clients seemed to fall into two camps when responding to an item on whether other members of their families had problems with drugs or alcohol. On the one hand, there were a group of clients who stated that they were the "black sheep" of the family and that no other family member was a drug user. On the other hand, there were a group of clients who commented on their father's alcoholism or the drug use of their siblings. In one case, for example, four brothers from the same family all had serious problems with heroin use. In any case, their exposure to chaotic drug use may be accelerated, therefore having implications for their rehabilitation.

The partner's status as a user is also important - it is very difficult if a client is in a period of recovery and their partner is exposing them vicariously to the drug culture / drug way of life. This can take the form of "using" in front of the recovering user, "goofing" in their presence, stealing to facilitate their habit or "scoring". It has to be acknowledged that the clinics are attempting to recruit partners in order to minimise the kinds of risks outlined above and

maximise the benefits of partner support in rehabilitation. The efficacy of this approach needs to be considered and again, communication between the service providers is vital.

It is vital to support the client in their context. As such, if the kinds of situations outlined above are familiar scenarios for clients attending any future rehabilitation programme, they must be adequately supported. Extending the rehabilitation to the implementation of partner and family support groups would be important here, or support group for users with partners in attendance / co-counselling are also possibilities.

Childcare Supports

In order for clients with children to successfully participate in meaningful rehabilitation, it is imperative that there be quality affordable childcare services available to support them in their recovery. The provision of a crèche would be essential for children under five - operating while the parents attend their programme. Clients who are parents would benefit greatly from advice, help and the development of parenting skills. The advantages of this are two-fold: children are experiencing quality childcare and parents are aided in their parenting. It is recommended that existing childcare provision by a childcare agency (in this case, Barnardos) be extended to future rehabilitation programmes. Furthermore, existing childcare provision in both Patrick's Street and the Oasis Project needs to be maintained and further resourced.

Within the Health Board regions there are existing rehabilitation programmes that incorporate the building of self-confidence and self-esteem, the development of parenting skills and the increased opportunity to engage in positive parenting. Indeed, it has been commented on one such pilot programme that the child aids the clients' recovery. It is recommended that the service providers link in with these existing programmes in order to gain from their experiences.

Counselling Service

There is widespread belief in the importance and value of counselling for opiate addicts in Europe and internationally (Task Force Report (UK), 1995). The evidence from wider studies indicates that abstinence counselling appears to be most effective in reducing drug use / criminal behaviour and increasing health and well being (Hubbard et al., 1997; Simpson & Sells, 1990; Ball & Ross, 1991). Furthermore, the provision of intensive, individually based counselling to targeted individuals appears to be an effective strategy in improving treatment outcomes (Saunders, Wilkinson and Philips, 1995). Finally, one of the critical factors related to positive outcomes refers to the programme counsellors themselves. Specifically, this refers to counsellors who see their clients frequently and who can refer them to ancillary services as needed. These counsellors are more successful in treating drug users than their colleagues.

It was beyond the scope of this research to examine the kinds of counselling that clients were engaging in. What was noted, however, was that the counselling service was perceived by clients to be under-resourced and stretched to the maximum. It can thus be queried as to whether counsellors are physically able to see clients frequently and on an individual basis (as recommended above). Moreover, there are few ancillary services currently in place to which the counsellor can refer clients. The effectiveness of the counselling service is thus being hampered by a lack of resources and patchy coverage. It is recommended that this service be expanded, resourced and developed.

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APPENDIX 1

PROVISIONAL QUESTIONNAIRE

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7. Have you ever spent time in prison?

Yes ☐
No ☐

If 'Yes', in prison did you receive

A course on addiction ☐
A detox programme ☐
Not on drugs while inside ☐
No support ☐
Other ☐

If you received any help, was it

Very helpful ☐
Of some help ☐
Not helpful at all ☐

8. How would you rate your current physical health?

Excellent ☐
Very good ☐
O.K. ☐
Bad ☐
Very bad ☐

9. Do you want to be drug free?

Yes ☐
No ☐

10. What are the main things helping you with your drug problem? (You may tick more than one.)

Methadone maintenance ☐
Support of family ☐
Support of partner ☐
Counselling Service ☐
Employment ☐
Other (please specify) _____

11. What are the main barriers stopping you getting over your drug problem? (You may tick more than one.)

Drug use continuing in family ☐
Partners continued use ☐
Lack of supports ☐
Boredom ☐
Unemployment ☐
Lack of proper Accommodation ☐
Other (please specify) _____

12. Which of the following would you consider to be most important in helping you with your drug use?

- | | |
|-------------------------|--------------------------|
| Recreational Activities | <input type="checkbox"/> |
| Addiction education | <input type="checkbox"/> |
| More clinics | <input type="checkbox"/> |
| Residential detox | <input type="checkbox"/> |
| Counsellors | <input type="checkbox"/> |
| Peer support systems | <input type="checkbox"/> |
| Accommodation | <input type="checkbox"/> |

Other (please specify) _____

13. Indicate what supports you need to give you a better lifestyle

- | | |
|------------------------------------|--------------------------|
| 1. Education Support | <input type="checkbox"/> |
| 2. Training/Development Support | <input type="checkbox"/> |
| 3. Childcare Support | <input type="checkbox"/> |
| 4. Employment Support | <input type="checkbox"/> |
| 5. Family Support | <input type="checkbox"/> |
| 6. Other Supports (please specify) | _____ |

14. Have you ever attended a rehabilitation course?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

(Please specify) _____

If 'Yes' was this course useful?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

Why/Why not?

15. If there were a rehabilitation course with things like counselling, job skills, arts & craft etc., would you attend it?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

Why/Why not?

APPENDIX 2

FINALISED QUESTIONA1RE

DUN LAOGHAIRE RATHDOWN REHABILITATION SURVEY

No. _____ Interviewer _____

Date: ____/____/____

Location: _____

The purpose of this questionnaire is to get your opinions on Service provision in Dun Laoghaire/ Rathdown - it will be completely confidential and anonymous, no name required.

Please place tick in appropriate box.

1. Gender

Male	Female
<input type="checkbox"/>	<input type="checkbox"/>

2. Age

16-20	21-25	26-30	31-35	36-40	41+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. How long have you been attending current service?

- 1-4 weeks ☐
- 1 month-6 months ☐
- 6 months-1 year ☐
- 1 year-1½ years ☐
- 1½ years-2 years ☐
- More than 2 years ☐

4. Where are you living at the moment?

- In the Family home ☐
- Family Home of partner ☐
- Living with partner ☐
- Living alone ☐
- Living alone with children ☐
- Homeless (on the street) ☐
- Homeless (in a B&B) ☐
- Other (please specify) _____

5. How do you find living there?

- Excellent ☐
- Good ☐
- O.K ☐
- Poor ☐
- Very poor ☐
- Why? _____
- _____

6. Education to date

Primary Level	<input type="checkbox"/>
Group Cert Level	<input type="checkbox"/>
Inter Cert Level	<input type="checkbox"/>
Leaving Cert Level	<input type="checkbox"/>
Third level (PLC, etc.)	<input type="checkbox"/>
Other (please specify)	_____

7. Have you completed any training courses?

FAS	<input type="checkbox"/>
CERT	<input type="checkbox"/>
Other	<input type="checkbox"/>
Please indicate type of course	_____

8. Current Employment Status

Unemployed	<input type="checkbox"/>
Employed (Full-time)	<input type="checkbox"/>
Employed (Part-time)	<input type="checkbox"/>
Participant on a Course/Scheme	<input type="checkbox"/>
Other (please specify)	_____

9. Are you satisfied with your job?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
If 'No' say why	_____

10. Have you ever spent time in prison?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If 'Yes' indicate how long _____

If 'Yes', in prison did you receive

A course on addiction	<input type="checkbox"/>
A detox programme	<input type="checkbox"/>
Not on drugs while inside	<input type="checkbox"/>
No support	<input type="checkbox"/>
Other	<input type="checkbox"/>

If you received any help, was it

Very helpful	<input type="checkbox"/>
Of some help	<input type="checkbox"/>
Not helpful at all	<input type="checkbox"/>

11. How is your physical health?

Excellent	<input type="checkbox"/>
Very good	<input type="checkbox"/>
O.K.	<input type="checkbox"/>
Bad	<input type="checkbox"/>
Very bad	<input type="checkbox"/>

12. Do you have a hot meal every day?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

13. Do you eat a lot of sweet things?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

14. Do you take any physical exercise?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If 'Yes' please
specify) _____

15. Do you have many close friends?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If 'Yes' are these friends drug users?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

16. In the past did you have friends who were not drug users?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

17. Do you have contact with your own family members now?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

18. Do any of your family members have problems with drugs/alcohol?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

19. Are you in a stable relationship with anyone at the moment?

Yes ☐
No ☐

If 'Yes' do they have problems with drugs or alcohol?

Yes ☐
No ☐

20. Do you want to be drug free?

Yes ☐
No ☐

21. Are you taking any other medicines/drugs besides methadone?

Yes ☐
No ☐

If 'Yes' please specify) _____

22. What are the main things helping you to cope with your drug problem? (You may tick more than one.)

Methadone maintenance ☐
Support of family ☐
Support of partner ☐
Counselling Service ☐
Employment ☐

Other (please specify) _____

23. What are the main barriers stopping you getting over your drug problem? (You may tick more than one.)

Drug use continuing in family ☐
Partners continued use ☐
Lack of supports ☐
Boredom ☐
Unemployment ☐
Lack of proper Accommodation ☐
Other (please specify) _____

24. Which of the following would help you to stop taking drugs?

Things to do ☐
Addiction education ☐
More clinics ☐
Residential detox ☐
Counsellors ☐
Users support group ☐
Accommodation ☐

Other (please specify) _____

25. Indicate what supports you need to improve your lifestyle

- | | |
|--|--------------------------|
| 1. Education Support (eg., Adult Education, Literacy) | <input type="checkbox"/> |
| 2. Training/Development Support (Skills Course/Personal Development) | <input type="checkbox"/> |
| 3. Childcare Support | <input type="checkbox"/> |
| 4. Employment Support | <input type="checkbox"/> |
| 5. Family Support | <input type="checkbox"/> |
| 6. Other Supports (please specify)_____ | |
| _____ | |

26. Have you ever attended a rehabilitation course?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

(Please specify)_____

If 'Yes' was this course useful?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

Why/Why not?

27. If there were a rehabilitation course with things like counselling, job skills, arts & craft etc., would you attend it?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

Why/Why not?

If there are other comments that you would like to make in relation to drug rehabilitation, please state

THANK YOU VERY MUCH FOR YOUR TIME & PARTICIPATION

APPENDIX 3

“SURVEYING THE OASIS PROJECT”

DUN LAOGHAIRE RATHDOWN REHABILITATION SURVEY PRELIMINARY RESULTS FROM THE PILOT STUDY

RESEARCHERS:

**MARY DOHERTY
EMMA KATE KENNEDY**

DATE:

15TH OF FEBRUARY, 2000

REPORT COMPILED BY:

EMMA KATE KENNEDY

INTRODUCTION

The following is the preliminary report on the pilot study of the rehabilitation survey currently being conducted on behalf of the Dun Laoghaire Rathdown Drugs Task Force. This survey aims to

- (i) collect data regarding demographic characteristics that have implications for rehabilitation
- (ii) represent client perspectives on rehabilitation in the borough.

The following pilot study was conducted at the Oasis Project in Mountwood Fitzgerald Park, surveying the characteristics and attitudes of six participants. This report looks at

- (i) data collected re demographic information
- (ii) data collected re views of rehabilitation
- (iii) demographic characteristics and their implications for rehabilitation
- (iv) the questionnaire itself
- (v) further comments.

DEMOGRAPHIC CHARACTERISTICS

Gender

Female	5
Male	1

Age

16 - 20 years	1
21 - 25 years	3
26 - 30 years	1
31 - 35 years	
36 - 40 years	
41 years +	1

Accommodation

Family home	2
Family home of partner	
Living alone	
Living alone with children	2
Homeless (on the street)	1
Homeless (in a B&B)	1
Other	

Education To Date

Primary level	5
Group Cert level	
Inter Cert level	1
Leaving Cert level	
Third level (PLC, etc.)	
Other	

Two of the participants had engaged in other courses, one has done the ECDL and the other a City & Guilds in English and Maths, an IPPA course on childcare and various other courses on first aid, social studies and industrial sewing.

Current Employment Status

All six surveyed were currently participants on a course / scheme. (The Oasis Project is a C.E. scheme).

Forensic History

Only one of the participants surveyed had been involved in the prison service, although this was for a very short period of time. They had been offered a detox while inside, but was not there long enough to take it up. It is also interesting to note that the same client mentioned that they had spent time in detention centres.

Current Physical Health

Excellent	
Very good	
OK	3
Bad	2
Very bad	1

It should be noted that one of the clients volunteered that they were Hepatitis C positive and had cirrhosis of the liver. They mentioned that their condition had affects on both their drug use and their rehabilitation.

VIEWS ON REHABILITATION

There was an overwhelmingly positive response to becoming drug free, with all but one of the clients indicating that they wished to become drug free. Views on rehabilitation varied - see summary below:

Factors helping clients cope with their drug use

- 66% of those surveyed felt that *family support* was one of the main things helping them cope with their drug use.
- 33% felt that *counselling services* were positive in this regard, although one client commented that they had changed counsellors three times in the last year and a half. They had eventually stopped attending, due to (a) difficulties in establishing and maintaining a good client-counsellor relationship and (b) lack of privacy and confidentiality with regards to this service.
- 33% of the clients felt that having *employment* - by this they were referring to their participation on the scheme - was important
- Only 33% indicated that *methadone maintenance* was helping them cope, although it could feasibly be argued that without the maintenance there would be no coping strategies employed.
- One client felt that *partner support* was important
- One client indicated that there was *nothing* currently helping, although it was implied that this was to do with an accommodation crisis.

Barriers in getting over drug problem

- 66% cited *boredom* as the biggest barrier preventing positive rehabilitation
- Both of the clients who are currently homeless indicated *lack of proper accommodation* as a major issue. It is also important to note that one of the clients commented that they were unhappy about where they lived because I have a disabled daughter and my dwellings are not suitable for her development.
- 33% of the clients surveyed alluded to continued drug use (either in the family or of a partner) as a stumbling block in terms of rehabilitation.
- One indicated that *lack of supports* was a barrier.
- One client mentioned *stress /problems* as being another barrier

Important factors in helping clients stop using

- 66% indicated *recreational activities*
- 66% indicated *accommodation*
- 50% indicated *addiction education*
- 50% indicated *peer support systems*
- 50% indicated *residential detox*
- 33% indicated *counsellors*
- 33% indicated *more clinics*
- One mentioned that *family support* would be another important factor

Supports needed for a better lifestyle

- 83% indicated *childcare*
- 83% indicated *family supports*
- 66% indicated *education*

- 50% indicated *training and development*
- 50% indicated *employment support*

Prior attendance on a rehabilitation course

All of the clients surveyed were currently attending a rehabilitation course so the majority responded on the Oasis Project.

- One client commented that that had attended a rehabilitation course prior to coming on Oasis but felt that the first was not useful. They commented that the course was very overcrowded, wasn't very organised and that "I felt that we were just numbers".
- The majority of the clients surveyed were extremely positive about the current course (i.e. Oasis), with one commenting that it was very helpful, there was an opportunity for training and the crèche was a vital support. Other comments re Oasis included that the project combated boredom very well / kept the client occupied and that it "prepared [you] to enter a drug free life'. Others liked the variety of individual and group work.

DEMOGRAPHIC CHARACTERISTICS AND THEIR IMPLICATIONS FOR REHABILITATION

Gender

The statistics that we collected yesterday are obviously carrying an inherent gender bias. This is a likely explanation for the huge emphasis placed on childcare and crèche facilities. In any case, there is a demonstrable need for such care and facilities to be an integral part of any future rehabilitation programme.

Age

Age did not have a significant effect on any of the perspectives on rehabilitation, i.e. age does not seem to affect the view of the kind of service you wish to avail of. I would again reiterate, however, that the majority of those surveyed fell into age brackets that would indicate childcare issues. It should also be added that recent research suggests that the younger you are when you begin any formal adult education process, the more successful you will be. The fact that the majority of the clients were under 25 does bode well for their positive participation in some kind of educational programme.

Accommodation

As would have been assumed intuitively, the pilot study does support the conclusion that accommodation issues would need to be dealt with either prior to entry onto a rehabilitation programme or as soon as is feasible from date of entry. Lack of proper accommodation severely curtails any confrontation with drug issues.

Education

The fact that the education level of the participants surveyed does not exceed primary level in most cases does have serious implications for any rehabilitation programme. This comment is made in light of the fact that literacy is a big problem - any programme would need to either (a) combine an element of literacy skills along with other elements and / or (b) avoid to a large extent reliance on written resources. It would be defeating the purpose of the programme to give handouts / worksheets / timesheets / written counselling 'tips' / written medical advice when such a problem exists. It should be noted that two of the six participants could not read or write sufficiently to make even a superficial attempt at filling in the questionnaire. All of the participants found the language level to be difficult

Current Employment Status

All of the participants surveyed were participants on a course I scheme. All of them had positive comments to make about how this employment was meaningful and very helpful.

Forensic History

Only one of the participants had been inside at all, and sufficient information is not available to make any kind of formal conclusion in this regard.

Physical Health

I think that this is an important area that may need expansion upon. None of the participants would class their current physical health as being anything above O.K. Regardless of precise medical diagnoses, the fact that the clients themselves feel unwell does have serious implications for rehabilitation (in terms of commitment and motivation). I would also go as far to

suggest that the lack of physical care taken by addicts while using does point to the probability that nutrition in particular and physical health in general is an issue.

As a general point of information, one client expressed huge dissatisfaction with the lack of a needle exchange in Dun Laoghaire Rathdown, and perceived the situation to be a complete lack of support on the part of the Health Board, etc. for drug rehabilitation. It should also be noted that the general tone of this participant was quite negative and accommodation issues were at the forefront

THE QUESTIONNAIRE ITSELF

The questionnaire itself presented a significant number of problems to the researchers. I should add an additional comment at this point that the participants had a somewhat jaded view of filling in questionnaires and felt that they were often asked for their perspective as a “lip-service”. After explaining who we were and what kind of information that we wanted, there was a very helpful and articulate discussion on views around rehabilitation.

Literacy is an issue for a great deal of the clients in this population group and there is an obvious need for non-patronising and non-condescending support around this issue- In any case, any kind of written questionnaire is going to encounter such a difficulty and it is unlikely that oral interviews would be feasible at this moment.

The language of the questionnaire is far too removed from the daily language of the participants, to such an extent that the questions had little initial meaning for them. The following examples were cited:

- Current status re accommodation
- Current employment status
- Recreational activities
- Peer support systems

Some of the questions were a little obtuse and their meaning was extremely unclear. The following examples were mentioned:

- What are the main things helping you with your drug problem?
- Which of the following would you consider to be most important in helping you with your drug use?

The researchers when discussing the questionnaire with the client replaced all of these phrases and questions. (I have made these changes to the 4th draft of the questionnaire - see attached).

There was no space on the questionnaire for client comments, thus appending no value to unsolicited information / viewpoints. Such comments were either written in by the client or the researcher.

As outlined above, some of the questions have been altered and there have been some additions made to the questionnaire (see Q.5, 7, 12, 13, 15, 20, 21, 22, 23, 24, 25). The majority of these questions relate to two areas that were not covered in the original questionnaire - family and social life / skills. The reason for their inclusion at this point is that the vast majority of clients cited boredom as being the major barrier in overcoming their drug problem. I don't think that we will get an adequate picture of the current lifestyle of the clients in question if we neglect to survey their current situation in this regard. I also think that in terms of rehabilitation, any programme should **draw on supports already in place and owned by the client**. In other words, the rehab programme should attempt to foster these family and social supports and if they are not in place, to address such these issues. Obviously, this is a provisional inclusion and would necessitate the full approval of the Task Force.

It should finally be noted at this juncture, that the restricted number of clients obviously calls into question the validity and reliability of the results collected. It is only with a bigger sample that one can draw more stable conclusions.

FURTHER COMMENTS

I cannot reiterate enough the need for both the clients and the workers to be fully and accurately informed of the purposes and procedures of this survey. I also believe that adequate time and space for a one-on-one interaction would be very desirable. That is not to say that the survey could not be conducted in waiting rooms, etc. It would just need to be emphasised that it is private and confidential, and that a quiet space within such a room would be more than adequate. I do think that the difficult and obtuse language and questioning styles will need to be remedied, and this would reduce the need for one-on-one interaction.

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