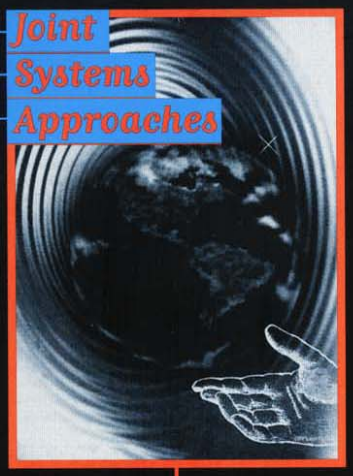
Joint Systems Approaches



for the

[Prevention]

of

DRUG MISUSE

Conference Report

(Collection of Papers & Discussion Summary)

6 November 1996, The Shelbourne Hotel, Dublin, Ireland.

Joint Systems Approaches For the Prevention of Drug Misuse

The Shelbourne Hotel

6 November 1996

Hosted By
URRÚS – Ireland's Community Addiction Studies Training Centre
(A Ballymun Youth Action Project Initiative)

Conference Report
Collection of Papers & Discussion Summary

“The drugs problem is what the Strategic Management Initiative in the Public Services describes as a ‘cross-cutting’ issue which cannot be dealt with satisfactorily by any one Department...

If the programmes and services which they provide are to be delivered in an effective, efficient manner, it is absolutely essential

that practical and workable arrangements be put in place to ensure a coherent,

co-ordinated approach.”

–First Report of the Ministerial Task Force on the
Measures to Reduce the Demand for Drugs
(October 1996)

Joint Systems Approaches for the Prevention of Drug Misuse

Executive Summary

This conference proved to be a rich exploration of the complexities involved when focusing on the systems concerned in the prevention of drug misuse. Minister Liz McManus describes how the *"First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* "(October, 1996) recognised drug misuse as a "cross-cutting issue", involving an approach which can bring together all relevant agencies and interests to work together.

Deeply entrenched problems, for which there are no obvious or easy answers, test our systems to the limits of endurance. Systems can respond by a) changing and growing to meet the challenges or b) falling back on techniques of survival, rationalising, minimising, projecting and denying the extent of the harm.

Joint Systems Approaches focus on the systems and the patterns of interaction. Systems are in constant inter-relationships with each other. Bringing systems together, with the wealth of literature available within each, brings a rich cross-fertilisation and presents an alternative theoretical framework to the linear model.

However, as pointed out by Robbie Gilligan in his presentation, there are many difficulties involved for professionals in working together. Pat Dolan reminded us that one of the vital roles of services is not to undermine the natural helpers, such as family, friends, or peers. He offered us hope through the practical tool of the *Social Network Map,* a theme which was returned to by Peter Steen Jensen and by many participants throughout the day.

Annemie de Loose from Belgium offered a definition of a network as "a way of co-operating in which the participants give up part of their autonomy out of respect for the other's work and, in doing so, increase their own influence."

We learned from Jack Houlahan's experiences in Northern Ireland, where the divisions between purchaser and provider have led to competition among agencies, rather than co-operation, and protection of ideas, rather than sharing of vision and plans. In addition, the "packages" of care have not tapped the range of skills and knowledge within communities, an issue which is very much to the fore in Dublin.

Executive Summary (Continued...)

That our systems are part of the dynamics of drug misuse seems to be agreed. Yet, going beyond rhetoric to change is easier said than done! Participants, in their workshops, explored these difficulties, and by all accounts there was a lot of energy and discussion, which is impossible to completely capture.

Drawing from the wealth of knowledge and experience, and from research from various fields, we can say with confidence that:

1) agents within the various systems involved need legitimacy within their roles for working in networks;

2) agents need their levels of confidence and adequacy improved through appropriate training, and supervision;

3) on going consultation with specialist agencies is essential to effectiveness;

4) changes in practice, which come about through working with and not for communities, need to be recognised and supported by policy makers;

Through the Ballymun Youth Action Project's initiative, URRÚS – Ireland's *first* Community Addiction Studies Training Centre, we have been actively working on these four areas. The success of this work was evident at this conference. The contributions from our guests, combined with the participation of those present, showed that this process can serve as a catalyst for change in Ireland, to make our systems truly comprehensive and child centred. We are not alone in Ireland in struggling with these complexities, and our transnational approach offers much hope for future learning and research in this essential area.

END.

"Joint Systems Approaches focus
on the systems and the patterns of interaction"
–Mary Ellen McCann

Contents

Introduction

Conference Aim

The aim of the conference was to explore ways to improve and develop services for the care of young people at risk in relation to drug misuse in Ireland.

Background

On the 6th of November 1996, URRÚS - Ireland's Community Addiction Studies Training Centre (A Ballymun Youth Action Project Initiative) hosted a day long conference entitled "Joint Systems Approaches for the Prevention of Drug Misuse" at the Shelboume Hotel, Dublin.

The conference, outlined in the Ballymun Youth Action Project's *EU Employment – Horizon* "Project Action Plan," was organised by URRÚS. It involved URRÚS's three transnational partners: De Sleutel, Belgium; Odense Magistral, Denmark; and Northlands Institute, Derry. The transnational partners promoted the concepts of integrating local and professional knowledge and the need for flexible short-term programmes to address the needs of various target groups. They presented case studies from their host countries on how to make strategies for the prevention of drug misuse more integrated, therefore, coping more effectively with the multi-disciplinary nature of the problem.

The conference also featured two speakers from Ireland who explored issues around how to work together in the best interest of young people. Robbie Gilligan began with a slightly tongue-in-cheek look at some of the issues involved in why services fail to work effectively with young people at risk. He then explored key propositions which it is suggested should inform attempts at co-operation by professionals and organisations, and then considers the steps which organisations should take to facilitate professional and organisational co-operation. Pat Dolan introduced the Social Network Map which is a very practical and innovative tool in helping children access and mobilise social network support from family, friends, school, voluntary clubs and community.

Workshops, using case studies, were employed to allow conference participants to: learn from one another; explore various issues in relation to young people at risk; and participate in searching for ways to better work together for the benefit of Ireland's youth.

"Start where they are,
build with what they have"
–Lao Tse (700 BC)

"Joint Systems Approaches for the Prevention of Drug Misuse"

9:00 - 9:45 am	***Registration***
9.45 am	***Introduction***
	Ms. Mary Ellen McCann, Co-ordinator, Ballymun Youth Action Project Ltd.
	Opening Address
	Ms. Liz McManus, Minister of State at the Department of the Environment, with special responsibility for Housing and Urban Renewal.
10:00 -11:15 am	***Morning Session***
Chair	Mr. David Treacy,Director, Comhairle Ie Leas Oige.
Speaker I:	Mr. Robbie Gilligan, Head of Social Studies, Trinity College *"The How and Why of Working Together for Young Peopleat Risk"*
Speaker 2:	Mr. Pat Dolan, Co-ordinator of Adolescent and Family Services, Western Health Board *"Helping Children Through Social Network Support"*
11:15-11:45 am	***Tea & Coffee Break***
11:45-1:00pm	***Transnational Experiences***
Chair	Mr. Chris Moms, Assistant Principal, Probation and Welfare Service.
Speaker 1:	Mrs. Annemie De Loose, Head of Department of the Daycentre of Malines, Belgium. *"The Networks of De Sleutel and the Integration in the field of Health Care in Flanders."*
Speaker 2:	Mr. Jack Houlahan, Training Co-ordinator, Northlands Institute, Derry, Northern Ireland *"Care in the Community: Are People Really First? An Overview from Northern Ireland: Pointers for the Future."*
Speaker 3:	Mr. Peter Steen Jensen, General Manager, Odense Kommune, Denmark "*Visions from the City of Odense's Municipal Department 5 (Children and Youth): Concerted action on child development - with special focus on prevention of drug abuse.***"**

"Joint Systems Approaches for the Prevention of Drug Misuse"

1:00-2:15pm ***Lunch***

2:15 - 3:30 pm ***Workshops***

Workshop Facilitators:

Ms. Audrey Kilgallon, Addiction Counsellor, National Drug Treatment Centre, Dublin

Mr. Chris Murphy, Director, Drug Awareness Programme, Crosscare, The Catholic Social Service Conference, Dublin

Ms. Marion Rackard, Senior Counsellor, Community Alcohol Services, Tallaght

Ms. Siobhan McGrory, Health Education Officer, National Youth Council of Ireland, Dublin

Ms. Ruby Morrow, Psychologist, Department of Education, Dublin

Ms. Brid Burke, Co-ordinator Family Support Services, Community Response, Dublin 8

3:30-3:45 pm ***Coffee***

3:45 - 4:45 pm ***Plenary Session:***

Chair: Ms. Brid Clarke, Director of Child Care and Family Support Services, Eastern Health Board, Dublin

4.45 pm ***Close***

Mr. John Adams, Training Centre Co-ordinator, URRÚS - Ireland's Community Addiction Studies Training Centre.

Speaker Profiles:

Ms. Liz McManus, Minister of State at the Department of the Environment with special responsibility for Housing and Urban Renewal.

Minister McManus is a member of Dail Eireann and of the Ministerial Task Force on Measures to Reduce the Demand for Drugs established by the government on 9 July 1996. As a member of the Democratic Left Party, she was appointed Minister for Housing and Urban Renewal in 1994. Her previous work includes: serving as chair of the Task Force on the Needs of the Travelling Community; serving as spokesperson for Democratic Left on Environment, Equality, and Law Reform and Agriculture, and establishing the Women's Refuge in Bray.

Mr. Robbie Gilligan. Head of Social Studies. Trinity College

Robbie Gilligan is Head of the Department of Social Studies and Senior Lecturer in Social Work at Trinity College Dublin. He is also Academic Co-Director of the Children's Centre, Trinity College. His major professional and research interest is the broad field of child and family welfare in which he has served as social worker, foster carer, researcher, author, trainer and board member of voluntary bodies. His publications include *Irish Child Care Services: Policy, Practice and Provision (Dublin: Institute of Public Administration, 1991).*

Mr. Pat Dolan. Acting Co-ordinator of Adolescent and Family Services. Western Health Board

Pat Dolan moved to his present position from having been Project Leader with the Westside Neighbourhood Youth Project, a specialist day care support service for adolescents. Pat originally established this project for the Western Health Board in Galway in 1990. Pat has worked in residential care and for eight years also worked in St. Annes Galway, a Child Guidance Residential Service for Adolescents. Pat originally trained in Child Care and has also completed the Advanced Diploma in Child Protection and Welfare, Dept. of Social Studies, Trinity College Dublin (1993). At present, Pat is completing a Post Graduate Degree with Trinity College. As part of his research degree Pat is exploring how parents of adolescents access and mobilise social network support. For the last 12 years Pat has been involved with the Irish Association of Care Workers and is currently their National Spokesperson.

Ms. Annemie De Loose, Head of Department of the Daycentre ofMalines, Belgium.

Annemie De Loose worked in a Daycentre in Antwerp for 4 years as drug assistant. For the past 2 years she has been co-ordinator of a new day centre of "de Sleutel" in Mechelen. This centre is characterised by a low threshold with a multi-disciplinary approach. Because of the very young population in this centre, it demands a groupwise method and activities which are focused on the system. Besides her base education (assistant psychologist), Annemie has completed many other courses, e.g. management in health care, an introduction in short therapy (Korzybski) and pharmacology. Within the network of 'de Sleutel", she's also responsible for the implementation and follow-up of diagnostic instruments, e.g. the addiction severity index, for which she completed a course as a trainer. Besides the internal work, she's active in the field of prevention (lecturing and advising school principals in the setting up of drug policies).

Mr. Jack Houlahan, Training Co-ordinator, Northlands Institute, Perry, Northern Ireland.

Jack Houlahan has been working in the addictions field since 1980 and has been a tutor on Certificate in Addiction Studies at University of Ulster Magee since 1982. He is a tutor on Certificate in Counselling (University Ulster) and he is also responsible for the Module *Images a Models of Addiction* which is part of the M.Med.Sci. (Addiction Studies) jointly offered University of Ulster and Queens University. He served on the first Executive Committee of Irish Association of Alcohol and Addiction Counsellors (IAAAC). He is chairperson of Northwest NVQ Assessment Centre (Social Care). As a trainer and facilitator Jack's interest is empowering people in direct contact with the impact of substance misuse and other forms dependency to respond directly within their own situation. He facilitates groups seeking to clarify their roles and the range of their services, and offers customised Training of Trainers and other training programmes. His radio play, *Maiden City Magic,* about a young girl coming to terms with her policeman father's alcoholism was the BBC's entry for the 1993 *Prix Italia.*

Mr. Peter Steen Jensen, General Manager, Odense Kommune, Denmark.

Peter Steen Jensen, a former school teacher, is presently General Manager of Odense Municipality Number 5 (Children and Youth) which consists of 5,215 employees. Prior to taking up his present position, Peter was General Inspector of Education at the Danish Ministry of Education from 198

1993. From 1987-1989, Peter was Educational Adviser, at the Department of Education's Primay and Lower-Secondary Education. From 1982-1987, Peter was Subject Adviser at the Department Education's Primary and Lower-Secondary Education.

"How is it possible to convince
a child of his own worth
after removing him from a family
which is said to be unworthy,
but with whom he identifies?"
–Maya Angelou

Opening Presentation

Minister Liz McManus TD

Ten years ago the administration and the media in Ireland woke up to the existence of a national drugs crisis. That drugs crisis was largely concentrated in Dublin, mainly in deprived working-class areas, and was essentially a heroin problem. The nation woke up to the problem....briefly. And then it turned away, turned a blind eye to a nasty but contained problem.

Yet the problem never went away. Today the nation has woken up to what it sees as a new drugs crisis. Elected representatives have been grappling with the problem over the last 10 years, particularly those representing certain Dublin constituencies. The regional health and social services engaged in fire-fighting, and with inadequate resources. Local government could have, and should have, played a more important role. The Drugs Squad did what it could, and individual Community Gardai did what they could to develop a proactive and preventative approach to drugs. The prison system, which might have been part of the solution became, in the eyes of critics, part of the problem.

One could be forgiven for thinking that it is almost as if the nation wilfully blocked out the problem because of its global scale: wilfully blocked out the havoc wreaked on individuals by the addiction; wilfully blocked out the havoc wreaked on society by the resultant crime, the crime lords and the drug barons; wilfully blocked out the deaths, the destruction of human lives and urban communities, the social decay and the economic disintegration.

The causes and consequences of the drug problem are closely intertwined. The sources of the problem are external and internal. There are international and national dimensions to it. There are economic forces at work. The response must therefore be multidimensional. Responses at official level have heretofore been rather piecemeal, and there was a definite need to pull these initiatives together into a coherent strategy. An awareness of how current and past educative and preventative efforts have impacted, together with an awareness of the statistics and trends in the areas most at risk is essential. That is why I welcome the holding of seminars such as this one, and I am delighted to be able to address you today, to express my support, and also to offer a little on the most recent initiative taken by this Government in an effort to construct a comprehensive and co-ordinated response to the problem.

We must not seek refuge in the observation that this is a world-wide phenomenon, although there is a commonality everywhere where drugs misuse occurs: The strong correlation between drug abuse and social, economic and physical marginalisation of working-class communities is a fact of life. And I do not doubt that the experience in Belgium and Denmark is the same. I look forward to hearing about these experiences in tackling drug misuse later today.

At the moment in Ireland, there is no census of drug addiction. But we can count the numbers presenting for treatment, the addicts who have finally decided to seek help, to seek treatment, to seek to rehabilitate themselves and overcome their addiction. Poverty and neglect have disfigured Irish society and it is no coincidence that the drugs crisis has its greatest hold in areas where unemployment, poverty and social exclusion are rife. The greatest numbers presenting for treatment come from socially and economically disadvantaged areas. These areas are characterised by chronic levels of unemployment, often poor living conditions, high rates of early school leaving, high levels of family breakdown and a general lack of recreational facilities and other supports.

The fact was also fully supported in submissions received, by the recent Irish Ministerial Task Force on Measures to Reduce the Demand for Drugs, from over 120 organisations and individuals who responded to our invitation to make their views known on how the drugs crisis might best be tackled. Many of these organisations and individuals are “working at the coalface” in combating

the drugs problem, so their views are particularly relevant. As a member of the Ministerial Task Force, I would like to take this opportunity to thank them for making submissions and to assure them that their views were taken fully into consideration by the Task Force in preparing our report. The correlation between addiction and social and economic marginalisation dictates that economic policy must have a role in defeating the scourge.

This Government, through initiatives such as the Local Employment Service (LES), through the Community Development Programme, through the strengthening of the Partnerships, through budgetary and tax and welfare policies, is concentrating significant resources on the urban economic and unemployment priority areas. To the extent that these policies prove successful, they undermine the mutually reinforcing causes of the downward spiral of which drug "blackspots" are another manifestation.

In making a connection between these policies, initiatives and efforts and the war against drugs, community and voluntary groups and the partnerships have a key role to play in conjunction with the State - as is recognised by the Ministerial Task Force and the recently published First Report from this Task Force. The focus of this report is demand reduction policies and measures. However, as I have said, the overall approach must be integrated and comprehensive, multi-dimensional.

In attempting to analyse the extent, not only of the heroin problem but, of the misuse of drugs in the country generally, the Task Force was struck by the lack of concrete data available on the subject. This is a situation which is common to all countries with a drugs problem - reflecting the fact that the activity itself is illegal.

It is absolutely essential that we have valid, definitive information on the scale and prevalence of drug misuse. This data is necessary:

- To accurately quantify the extent of the problem;
- To assist in the targeting of the drug services, ensuring that an appropriate mix of preventative, treatment and punitive measures is provided;
- To monitor the progress and effectiveness of these services;
- To undertake epidemiological research;
- And to help determine the appropriate level of Exchequer funding for the drugs services.

Those who are poor, often with limited educational aspirations, very limited employment prospects, and a depressing physical environment, are likely to be vulnerable to a drugs habit which, at least initially, may seem to offer escape and excitement. This is particularly the case when family and personal difficulties compound the social problems. Given a ready supply of drugs, such communities are likely to produce a number of heroin abusers who, in turn, are likely to become small-time suppliers, to finance their habit. A cycle of drug abuse is likely to stem from this, further compounding the employment and environmental difficulties of these communities.

It has to be stressed that the majority of families and young people living in even the most seriously drug-affected areas are not themselves drug misusers. In the vast majority of cases the people living in these areas are seeking better lives for themselves and their children and take legitimate pride in the strengths of their community. This is enhanced by the vast range of voluntary and community effort in these areas. However, it is easy to understand how a community may feel overwhelmed by the scale of the drugs problem and the threat which it poses to its young people. This is especially the case where such communities already suffer from other manifestations of social exclusion. Many of these communities have felt compelled to take direct action to deal with the drugs problem in their areas. It is understandable that, given what has been perceived as an absence of a clear and convincing response from the public authorities to date, communities may tend to find heart in resorting to such action. But, by leaving the root causes of drug addiction untouched, they are

untouched, they are ultimately futile. That being said I believe it is possible for the Government to assist communities with ways and means of protecting themselves against the menace of drugs.

This Government has adopted all of the recommendations made in the first report of the Task Force, and has allocated £14 million additional spending towards their implementation.

£10 million is earmarked for service development in the eleven selected areas where the drugs crisis, and particularly the problem of heroin abuse, is most acute. £3 million is being allocated towards local estate improvement measures, while a further £1 million is being set aside for specific anti-drugs projects in Health Board regions outside of the priority areas in Dublin and Cork.

In addition, new structures are being put in place to ensure that the drugs problem is tackled in a more coherent, integrated manner than it has been to date. A Cabinet Drugs Committee, chaired by the Taoiseach, will give overall political leadership in the fight against drugs.

A new National Drugs Strategy Team will report directly to the Cabinet Committee and will have the responsibility of ensuring that the Government's anti-drugs strategy is being implemented effectively.

Structures are also being put in place in the areas most ravished by the drugs menace. These structures are being designed to ensure that the relevant statutory agencies work in partnership with voluntary and community groups in delivering the most appropriate mix of services to tackle the drugs problem in the priority areas. It is essential that communities be involved in a positive way in all aspects of the fights against drug abuse. The Task Force are particularly anxious that they play a full role in the demand reduction strategies which we have developed in our Report.

Community involvement was a point which was made in many of the submissions received by the Task Force and is perhaps best reflected in the submission from the Combat Poverty Agency (CPA). In its submission, the CPA emphasised that local groups and individuals have a very valuable contribution to make to the development of a national drugs policy. Having been involved in tackling the drugs problem in their respective areas over a number of years, such communities have built up a considerable and valuable experience which should be tapped as a resource. The Task Force wholeheartedly endorses this view.

There is unanimous agreement, among everyone involved in fighting the drugs crisis, that programmes to reduce the demand for drugs must consist of a comprehensive, co-ordinated package, comprising treatment, rehabilitation and prevention. As well as bringing the treatment waiting lists under control, we must also assist stabilised misusers in their rehabilitation and re-integration into the community. This is an issue which needs to be addressed immediately.

There is no doubt that prevention is an area which we must address vigorously if we are to successfully overcome our drugs problem. Prevention measures in areas such as estate management, local development, and youth and sports programmes can contribute to a reduction in the demand for drugs. The Government also fully supports the recommendations of the Report which deal with education. These place particular emphasis on early intervention and envisage the Education Partners - that is, the boards of management, teachers and parents - working together in the design and delivery of fully piloted and properly evaluated anti-drugs programmes in our schools.

Government proposals further envisage the appointment of additional home/school liaison officers and teacher counsellors, an expansion of that scheme as well as the provision of appropriate training for those developing the anti-drugs programmes. I am particularly hopeful that these measures will make a significant impact on the problem, especially in the areas which we have identified for priority action.

The commitment to overcome the drugs problem must extend to the highest political level. It is for this reason that we recommend the establishment of a Cabinet Drugs Committee, chaired by the Taoiseach, to give overall political leadership in the fight against drugs. This committee also comprises the Ministers for Health, Justice, Education, Science and Technology, and the Environment.

It will:

- Oversee implementation of the proposals in the Task Force Report;
- Review trends in relation to the drugs problem;
- Assess progress in the strategy to deal with both its supply and demand aspects;
- Resolve any policy or organisational problems which may inhibit an effective response from the statutory agencies.

The National Drugs Strategy Team will report directly to the Cabinet Committee. It will be cross-departmental, and will comprise key personnel from the main Departments involved in drugs reduction strategies, as well as representatives from the relevant statutory agencies. Persons with a suitable background in voluntary/community work in the drugs area are also being invited to participate in the Team. While responsibility for implementing the individual elements of the Government's anti-drugs strategy will remain with the relevant ministers and their Departments, the team will ensure that the overall strategy is being implemented effectively and in line with Government policy.

Apart from ensuring that the structures at national level are ready to meet the challenges presented by drug misuse, the task force was anxious to ensure that appropriate structures were put in place at regional and local levels. At regional level, the co-ordinating committees which are being established in each Health Board area are the most appropriate structure to ensure a coherent anti- drugs strategy.

At local level, a new approach is needed. Special emphasis must be placed on those areas worst affected by the drugs problem, and in particular the heroin problem. The approach must bring together all relevant local agencies - statutory, voluntary and community - to ensure that they are working in tandem in fighting the drugs problem in their respective areas.

For this reason, the Task Force has recommended the establishment of local drugs task forces in each of the identified priority areas. These task forces will comprise representatives of relevant agencies, such as the Health Board, the Gardai, the Probation and Welfare Service and the relevant local authority, along with community representatives and a chairperson to be nominated by the local partnership company.

The relevant Health Boards have already been requested to nominate co-ordinators, whose job it will be to convene the first meeting of the task forces and assist them in their work thereafter.

We now have a government and a policy that acknowledges the problem of drug misuse, recognises its seriousness, is committed to fighting it, has put enormous public resources at the disposal of the relevant authorities, and has put new structures in place to ensure that never again will we manifest indifference towards the marginalised communities or leave them and the people who live in them to fend for themselves.

I am firmly convinced that the effective State action, in partnership with the local communities affected, can seriously tackle the drug problem over time, can rebuild these communities, enhance and improve them in terms of their physical and social infrastructures, and revitalise them economically. That is why seminars such as this are so important. Commitment, along with an awareness of what has not worked in the past, combined with the expertise and experience of those specifically involved in the field, will lead us closer to developing meaningful and effective joint systems for combating drug misuse. It is no longer enough to apply first-aid solutions, because

these are not solutions: Drug misusers are members of society, not outside of it. It is therefore the problem of the whole of society, not just a part. The problem of drug misuse is caused by many factors, and thus affects society and the individual in a variety of ways. To tackle it, we need to take a holistic approach, and treat the parts of the whole, tackle the sources which lead to the problem as it manifests itself. It is only then that the problem will begin to reduce, only then that crisis management will be replaced by strategies that have some chance of success by virtue of their wide-ranging, far-sighted approach. Joint systems and approaches are the only way forward in combating something which affects many systems.

I thought the most useful presentation I could make was to outline the Irish experience and strategy, but 1 am also eager to leam of the approach undertaken by our partners. The issue is such a critical one for the future of our young people that we need to consider all possible options.

In conclusion, then, I would like to commend and congratulate the organisers of this timely seminar. The range of speakers and sharing of expertise speaks volumes about the degree to which we have developed in our handling of drug misuse, and also reflects the degree of commitment on the part of those who have given so much of their time and energy to one of the most pressing issues with which we are confronted at the end of the Twentieth Century.

END.

"There is unanimous agreement, among everyone involved in fighting the drugs crisis, that programmes to reduce the demand for drugs must consist of a comprehensive, co-ordinated package, comprising of treatment, rehabilitation and prevention"
–Minister Liz McManus

Response to Minister by
Mary Ellen McCann, Project Co-ordinator, Ballymun Youth Action Project

I would like to thank Minister McManus for her presentation. I welcome the government's recognition of the clear link between social disadvantage and drug abuse. I also welcome the allocation of extra budgetary resources being made available for tackling this complex issue. I would like to ask the Minister to draw the Task Force's attention, in their future work, to the knowledge which is growing from our communities' experience of "partnership." This is a complex strategy, and rhetoric does not mean practice. The difficulties in converting rhetoric to practice have not been understood, and the necessary analysis of relationships has not been undertaken. We have learned from our experience of partnerships, in the Area Partnerships, in groups such as Ballymun Task Force, and from the experiences of the first two C.D.T's in Ireland. We know also that these communities are experienced in Community Development, which has been the approach they have had to use to combat major social problems. From those principles we know that representation does not equal participation. I urge the Minister, at this point when new structures, are being introduced and resourced, to ensure that these lessons learned over the last 15 years in community development and drugs work, are used in the implementation of the recommendations of the report.

By doing this a step can be taken from the rhetoric, to the practice of truly joint systems approaches for the prevention of drug misuse.

"Relationships become much more tricky than the old powerbased ones"

"Where do we get the skills to build new relationships?"

Robbie Gilligan **The How and Why of Working Together for Young People at Risk**

This paper begins with a slightly tongue-in-cheek look at some of the issues involved in professionals and services **failing** to work effectively with young people at risk and with the key players in their lives. The reader is left to decide which if any pan of the cap fits! The paper then draws positive lessons from this prescription for failure. It looks at key propositions which it is suggested should inform attempts at co-operation by professionals and organisations, and then considers the steps which organisations should take to facilitate professional and organisational co- operation. The paper ends with a postscript which poses a few questions in relation to the recommendations of the "First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs". This report is of course an exciting watershed in public policy in terms of addressing issues of institutional co-operation in tackling social problems.

How to fail in work with young people at risk (or why we need to work together)

Failure in work with young people in difficulty is certainly not unknown. It may take different forms: the young person doesn't engage with what we have to offer, the intervention doesn't make a difference, what we do doesn't seem to make sense to parents, the young person, or perhaps even to professionals themselves.

This work is demanding, complex and without simple answers. But perhaps we make the work even more difficult for ourselves. I would suggest that failure is often linked to a pre-occupation with the problem in isolation rather than seeing it in its context. There is often a complete focus on deficits rather than strengths. Failure may also be linked to ignoring or blaming key players in the child's life, whether they be parents, relatives, schools, or other professionals. The risk of failure grows if professionals remain cocooned in their own world - view unable to see beyond their own assumptions and jargon and unable to hear the views of service user or others who may challenge cherished but failing ideas. Failure is almost assured if we look for simple answers to complex questions, if we try heroically to solve a multi-faceted problem single-handedly.

A Prescription for Truly Effective Failure in work with Young People at Risk

Guidelines/or Failure in Work with the Young People

- Focus on the problem, the problem and nothing but the problem
- Ignore the need for complex responses to complex problems
- Look at the young person alone and in isolation
- Ignore the social context and social influences in the young person's life
- Stress the failures and deficits in the young person's profile
- Be convinced there is nothing new worth learning about how to deal with the problem
- Ignore other views or other ways of responding to the problem
- Avoid looking comprehensively at the young person's history and circumstances

The above points relate to the fact that we are often transfixed by the **problem -** drug use, delinquency, non-attendance at school or whatever. We often fail to see the factors which promote, sustain or limit the problem. We often see the young person only as a problem. This of course may not be a very promising base from which to try to motivate the young person towards change. We further compound the problem by failing to recognise or harness strengths the young person may have which may be the foundation for building a solution. We often fail to look freshly at problems, challenge our own rules of thumb about problems and responses, or indeed to look again

at the information we have or need to make sense of the young person's development and predicament.

Guidelines/or Failure in Work with the Key Players in the Young Person's Life

- Ignore parents
- Or sometimes, better still, blame parents
- Ignore strengths and resources in the young person's social network
- Ignore grandparents or other interested relatives
- Ignore school as resources in young people's social development
- Don't explain how you do your job
- Don't tell people what you have done with a referral they have given you
- Always assume other people are acting in bad faith
- Make sure to avoid talking to other professionals about what they do, what their pressures and aspirations are
- Make sure not to talk to service users about how they find the service
- And don't look to service users for ideas about how to tackle their problem
- If in doubt, blame
- Blame somebody else for the way things are - another **professional, another service,** the parents - anybody will do
- Make sure not to see a working relationship as something that has to be worked at and cultivated
- Use jargon as much as possible to let other people know who's in and who's out
- Resist stoutly any temptation to look again at how you think or do things
- When stuck, say 'we don't have the resources' as a way of avoiding putting time into working together or any fresh thinking
- Also remember that when all else fails 'confidentiality' can be a very useful excuse for not co-operating with other people

We can rely on professional language, outmoded practices, prejudices, and downright ignorance to obscure important assets and resources in a young person's life. How often do we fail to see - or close out - key resources and supports as we struggle to ease a difficulty or at least not make it any worse?

Working Together - Working with Other Professionals and Other Services

There are at least three senses in which we may work together with and for young people:

- Professionals working together with the young person, family members or others in young person's informal social network
- Professionals working together with other professionals from different disciplines/organisations
- Organisations working together with one or more other organisations

It is important to appreciate that working together in any of these ways is challenging yet essential. Co-operation between professionals may be impeded by differences in status, professional training

and philosophies, different work practices, different duties and employers, different professional jargon, different legal obligations and more.

Apart from professionals, the organisations which employ them also need to think more about working together as greater demands and expectations of collaboration arise, through frameworks such as the Area Partnership Companies. Working together at an organisational level can mean many things, anything from courtesy contacts to merging of operations. If co-operation is to deepen beyond courtesy contact it can raise key questions for organisations. If they are to co-operate, they must decide if they are ready and willing to share:

- information?
- premises?
- staff?
- functions?
- budgets?
- the glory or the abuse!?

Organisations will have to address issues such as whether they are to be equal partners or whether there is to be a dominant - subsidiary relationship, and whether it is easier to co-operate by working through a new body which acts as a vehicle for co-operation and leaves the home organisation relatively untouched?

Below I set out a number of key propositions which may help us to avoid some of the pitfalls I set out at the beginning.

Working Together: Some Key Propositions

- Working together across professional or organisational boundaries becomes ever more essential the more complex the problems young people at risk present
- Working together across professional or organisational boundaries is not a natural instinct for professionals or a 'natural state' for organisations
- Working together demands changes in our ideas, attitudes and behaviour, whether as individuals or organisations
- Change is difficult
- Working together across professional or organisational boundaries is difficult
- Change can be - and needs to be - managed
- Working together needs to be managed
- Working together across professional or organisational boundaries will not happen just because we indulge in rhetoric or wishful thinking about it.
- Working together across professional or organisational boundaries will only happen effectively if we invest energy in making it work
- Working together across professional or organisational boundaries will only work if we attend not only to the tasks but also to the relationships and dynamics among the people and organisations involved.
- Just as it would be unthinkable to build a substantial building without using engineering and architectural knowledge, so also it is impossible to build effective partnerships without using the time and skills of people who have knowledge of how change works and how groups work
- Working together whether at a level of two different professionals, at the level of a Local Task Force or beyond requires planning, training and active management

How Organisations can Facilitate Professionals in Working Together

Working together may need to be a approached differently by professionals or organisations depending on the level at which co-operation is sought. Is it to be at the level *of this* young person, *this* family, *this* school, *this* peer group, *this* neighbourhood? Or is it to be at organisational, area, regional or national levels? If organisations are to facilitate any form of co-operation then it **is** suggested that they need to act in the light of the above propositions along the following lines:

- Recognise that working together is not a 'natural state'
- The 'weed' of isolationism in our work is rampant and must constantly be kept at bay
- Recognise that working together is not just about minding common *tasks* but is also about cultivating a common commitment to working *relationships*
- Recognise that working together comes about by cultivation rather than decree
- Give a clear mandate for co-operation from the top of the organisation
- Encourage 'entrepreneurs' in bridge building across different barriers
- Work to share information
- Use training to build understanding and support for the what, why and how of working together
- Use resources as a carrot for co-operation
- Create a space where in a sense everything is open for discussion
- Strive for a shared language about the issues
- Strive for tolerance of uncertainty and loose ends
- Use time and shared activities to build trust
- Lighten up! - Smile and laugh

At the end of the day, professionals and organisations should remember the acid test of whether cooperation is happening and effective, whether a service is integrated. The acid test is this. If the end user experiences the service as integrated then the service is integrated. A service is not integrated just because we think it is - or say it is.

Post Script:

A Few Questions about the New Local Drugs Task Forces

I should first of all say how welcome these proposal are and how much of a step forward they represent in public policy in terms of tackling not only drug problems but disadvantage generally.

My questions offered in a sympathetic and constructive manner are:

1. How local is 'local'? Is it local enough to achieve an integrated response to the needs of THIS Young Person? THIS Family? THIS School? THIS Neighbourhood?

2. Why is there no mention of schools in the list of agencies? Are schools not the logical focus of serious efforts to assist young people at risk or in difficulty before problems get too much out of hand?

3. Why is there no talk of the detailed HOW of integration? Service integration can begin like a euphoric and blind romance with a headlong rush to marriage and then all to early divorce, or at least separate bedrooms!

4. Integration/partnership/working together involves serious change within and across organisations. How will this change be ***managed*** in order to ease people gently into it - otherwise it will provoke fear and resistance and attempts at change will end up sabotaged. How are people to be trained in how to manage change and how to communicate across their professional and agency 'hedges'

5. Why **Systems -** electronic or otherwise - are being developed for sharing information?

6. What work is being done to develop a common understanding of what is entailed in different stages of work, e.g. assessment, treatment, prevention etc.?

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"If the end user experiences the service as integrated
then the service is integrated.
A service is not integrated
just because we think it is
or say it is."
–Robbie Gilhgan

Pat Dolan **"Helping Children Through Social Network Support"**

Firstly I would like to thank URRÚS for inviting me to address this very timely conference on collaboration towards preventing young people from entering the disastrous route of drug misuse. In this paper I will promote the use of social networks as a key medium in assisting children cope with and overcome actual and potential adversity such as alcohol and drug misuse. Apart from defining and describing social networks, I intend to demonstrate practically how networks can support children and their family. In the course of discussion I shall use practical examples from my work with the Western Health Boards Westside Neighbourhood Youth Project (a family support service for adolescents and their parents) in addition to supportive evidence from current literature. In particular I will introduce you to the Social Network Map which I believe is very practical and innovative tool in helping children access and mobilise social network support from family, friends, school, voluntary clubs and community.

In the past whereas traditional social work with children may have been perceived in terms of case work only, in fact its origins were geared towards working with not just the child who was experiencing difficulties, but also with his/her parents and other social network agents including peers school and community. With this ecological rather than case work approach in mind and for the purpose of this paper I am asking you the listener to forget totally about the symptoms of drug misuse for a moment. Rather let us concentrate on the core issue of how young people get social support and more importantly how they use that support to help them cope with the stresses (no matter what form they take) of growing up.

Social Network can come from two sources informal or natural supports and formally or professionally contrived supports. Parents and family members represent key sources of informal supports for children. Hopefully families provide children with many of their support needs be they instrumental support (clothes, food, a bed), information or advice support (education life skills training) or emotional support (hugs, listening and understanding, affection). Social support acts as a buffer to stress and where families function well, even allowing for temporary difficulty children thrive and grow as a result of adequate family care. However families are not the sole social network providers of children. Other important social supporters include friends, neighbours, schools and leisure and sports clubs. In this regard I would see schools (teachers and peers) as having particular potential in respect of social network support provision to children.

Unfortunately not all family's function well all the time and in cases where difficulties emerge services play a useful part as formal supporters to children. However one of the vital roles of services is not to undermine natural helpers such as family or friends and also not to make children purely recipients of help and "patientise them". Sometimes what may be required from professionals is not to support the child at all but to support the parent who is probably the child's key source of social network support. In additional to professional intervention, locally based community groups both formal and informal can provide key support to children and parents experiencing adversity. Unfortunately all to often when children need support most because of presenting problems, (be it acting out behaviour or drug misuse) as a result of having these same problems they are least likely to access the help they so desperately need. It is essential that children do not fall from the support net of their family, school and community.

Programmes provided by projects such as the Neighbourhood Youth Projects (NYP) and others offer children vital support under all three categories (i.e. Information \ Advice Emotional and Concrete Support). In addition because such projects are perceived by attendees as a "club", unlike attending a health clinic participation does not carry a stigma. In addition to receiving educative support such as canoeing training or pottery skills attainment, the NYP type service can provide children with emotional support through solution focused group work or individual supportive counselling or just through practical concrete support e.g. "a call from a staff member in the morning to get out to school where no one else in the house is up". These interventions may seem

mundane in the context of extreme drug misuse but very often in working with people I have found that small practical interventions can matter greatly in the long run. "From little acorns grew the great oak tree".

The Social Network Map

So far I have established how social networks can benefit children by giving them instrumental and emotional support. In addition I have described family and school as key social network agents. It is essential that in order to help children activate their social networks so as they can act as a buffer to potential drug misuse, this concept of social network support is not viewed as 'vague or woolly'. On a purely practical level and also from the point of view of saving time we on the NYP have found the Social Network Map a very useful 'friend'. The Social Network Map (SNM) is a practice tool which encourages clients to identify their perceived membership (informal and formal) of their social networks. The SNM is administered on a one to one basis and entails filling out two sheets (The map itself and an accompanying Grid). Having identified who is in their network, through the process of answering a series of questions and by use of the Social Network Grid, clients rate the performance of these nominees network members. These questions cover key aspect of social network functioning including types of network support received, criticalness by and closeness to network members, reciprocity and durability of relationships. The key to the success of the SNM lies in the fact that it is a simple instrument to understand and use and also allows children(12 yrs +) and adults to review and reorganise who gives them support and in what ways. The Social Network Map originated in the USA as part of the "Homebuilders Project". The Social Network Map (SNM) was pioneered by Dr. E. Tracy, Cleveland University and Dr. James Whittaker, Washington. (Note: Messieurs P. Dolan, WHB and R. Gilligan, TCD are currently coordinating use of the SNM in the context of Social Services in Ireland)

Conclusion

In this paper I have advocated the use of informal and formal social networks in helping children abate the potential or actual threat of falling into the drugs culture. I have cited family and schools as key players in providing young people with social support and advised away from dealing with drug misuse in the context of its presenting symptoms. Finally I have suggested that the Social Network Map is a useful tool for child care practitioners in their task of working with children at risk of drug misuse.

END.

"...One of the vital roles of services
is not to undermine natural helpers
such as family or friends and also not
to make children purely recipients of help..."
–Pat Dolan

Annemie De Loose

De Key: Development of a Network for the Care and Treatment Drug Addicts

1. General Introduction to the Organisation

1.1. Historical outline : origin and development of De Sleutel.

De Sleutel's history runs parallel with the development of the drug issue in Flanders (Belgium). In the early 70's drug addiction was comparatively unknown in Flanders. So, there was no ready-made solution. In 1973 some social workers looking for a solution, initiated a non-profit association, christened De Sleutel. Its object was specifically the treatment of young drug addicts, which required funds in the first place. In 1975 the first clients were accommodated on a farm at Mendonk. The model of the therapeutic community was based on Maxwell Jones's principles, but soon thereafter the model of a hierarchic therapeutic community proved to be more suited to the purpose

Because a specialised centre like a therapeutic community cannot be an island and in order to meet the growing need for rehabilitation centres for drug users, the therapeutic community was provided with a crisis centre in 1979. From 1984 a clear link between the surroundings of drug users and the health services was looked for. This gave rise to day centres with street comer work, ambulant care, issuing substitution medication and group treatment.

Concomitant with the growing numbers of centres, a change in the policy of organising the assistance came about. The different forms of assistance to drug addicts run the risk of creating a collection of ivory towers. Having the diverse centres functioning in co-operation with one another was a must: no service on his own can solve the problems created by the use of drugs. Each form of assistance has its own possibilities and limitations. In order to maximise the potential of change, the complexity and chronic character of drug addiction force us to exploit as efficiently as possible every one's capacities. The respective care centres should, therefore, not ignore the work of the others, but rather they should try to be complementary. A network, in our opinion, is not a number of centres that fulfil several functions fairly autonomous in a given region. Rather, a network is a way of co-operating in which the participants give up part of their autonomy out of respect for the other's work and, in doing so, increase their own influence.

Since 1993 De Sleutel has tried to realise this objective within its own organisation. The process is still developing and not yet fully realised. Moreover, there is the development of a network of centres and structures that are not under the umbrella of De Sleutel, for instance the agreements with the Court of Justice. In some prisons, groups are formed to prepare for treatment after the end of their term, and an experiment is going on with day treatment within the framework of semi-freedom.

1.2. De Sleutel as part of the Brothers of Charity network.

Since 1991 De Sleutel is a part of the Brothers of Charity. Therefore, it belongs to the mental health care sector. Besides medico-pedagogic institutes, this sector consists mostly of psychiatric centres.

The aims of the Brothers of Charity are to be found in their 'mission' declaration. This mission aims to stimulate its employees towards reaching its objectives. In its most general form this declaration is as follows : 'We, working in the mental care sector, want to render optimal assistance in a professional and inspired way, in the spirit of the founder, Peter Joseph Triest'. This mission becomes operational by means of nine critical objectives. They matter to De Sleutel e.g. because the mission declares that no discrimination against the "difficult" patients will be made, and drug users belong to that group. The Brothers of Charity, on the other hand, is aimed at rendering a differentiated assistance to all people who might need it, also searching for feasible

solutions for those who appeal to the Brothers of Charity due to the present deficient social welfare services. Here De Sleutel found a breeding ground for the development of the network of assistance to drug addicts.

2. The Common Task: What does a Network stand for?

A network is more than a collection of separate entities, otherwise we should speak of a multi-modality programme. A network can only function if it is based on a common set of philosophic values and therapeutic ideas. A network requires a combined framework wherein people strive to achieve the common objectives. It also has consequences with regard to the employees; polyvalence and identification come more to the fore than professionalism and individualism.

2.1. The Philosophy of De Sleutel

The objective of De Sleutel in a nutshell is as follows:

Treating drug addicts and influencing their environment so that they can re-integrate drug-free into society. Environment includes not only the drug abuser's family but the environment in its widest sense: policy makers of the departments and governments, the law, employers, etc. Re-integration is not just the task of a treatment network but it should also be the common objective of society in all its branches that want to achieve this aim by means of a well co-ordinated action.

De Sleutel does not pretend to be an island where drug users are living separated from society. On the contrary, re-integration into common social life is our explicit objective. What the drug user learns at the treatment centres is to be put into practice in the outside world. This is to be realised by means of homework and exercises given at the ambulant centres and by means of an after-care programme provided by the residential centres. De Sleutel organises treatment and professional training within the framework of the European Social Fund and the Horizon programme of the European Community. For those for whom re-integration in a normal job environment is impossible, other possibilities are offered to make socio-economic re-integration possible within the framework of planned social work projects. This becomes more important as we know that after successful treatment almost half of the total number of the recidivists have to face difficulties to find employment.

Providing feedback for society, however, is not just limited to treatment. Prevention, the support of initiatives outside our own organisation, and scientific research is also taken care of. The follow-up scientific research evaluates, compares and pays special attention to the problems relating to finding employment. This research is part of a Belgian project, TRTC (Training and Research in the Therapeutic Community), which in turn is part of a European research group concerning therapeutic communities, viz. TABLE. The primary motive of all the different sections of the care and treatment sector is that in principle no status quo but change is aimed at. In addition, De Sleutel wants to take responsibility for those drug users of whom it has been proven that their capacity to change is limited. The day-care centres in the large conurbation have separate treatment programmes for this group. There is co-operation with initiatives for psychiatric patients who need a protected environment, which results in extra possibilities for these addicts that have also psychiatric problems.

The primary motive that runs through the respective sections of the care and treatment with regard to the attitude towards the drug addict is that the drug user is not seen as a patient, a mentally or otherwise disabled person, but as a responsible person who is principally able to face the consequences of his choices. The latter aspect is most explicitly present in the hierarchically structured therapeutic community as the self-help concept, but the same principles are applied at the crisis centre and the day centres. It also means that the drug addict is considered to be able to learn not only from professional social workers but also from ex-drug users. Ex-drug users who after their treatment have for some years worked in other places and who took a professional

training in social sciences are very welcome to help out in our centres, adding an indispensable dimension to the whole.

De SIeutel considers addiction as a complex problem with somatic, social and psychological aspects. It implies that caring is not one-sidedly medical, social or psychotherapeutic but multi-disciplinary. De SIeutel wants to provide health care according to the above mentioned principles not only by means of the development of a multi-modality programme which is made available to the drug user according to his individual needs, but also by linking up various forms of health care. The process of rehabilitation has ups and downs, and it is our responsibility to see to it that this process takes place as efficiently as possible by avoiding to have to start from scratch time and again, and , by building on past treatments and by working towards future treatments.

2.2. The Clinical Elaboration of a Network : Processing Clients

A network can be static, called a multi-modality programme. It works as follows: the drug user presents him/herself at a centre, is treated there or referred to a treatment programme that seems to suit his/her needs. When he leaves the treatment is ended. There is little co-operation among the respective services; they just refer people and summary information is passed on. Every service does its own intake, applies its own insights and closes the dossier when the treatment has come to an end. A treatment can be finished if the client does not keep to the contract, if progress is unsatisfactory, if the situation of the client has stabilised and he/she is satisfied with it, if the objectives of the therapy have been achieved. In the end, there are more cases that are concluded against the advice of the people in charge than in accordance with it. In the latter case, the drug user will appeal again to a centre sooner or later, and the whole process will have to be repeated, mostly without much attention being paid to previous treatments.

De SIeutel, on the other hand, wants to make co-operation more dynamic. It is a fact that a drug career with its ups and downs evolves. Our vision is based, not so much on the fact that various centres should be available to different types of drug users, but rather that the same drug user is not always in need of the same treatment in the course of his drug career, on the contrary, he should be able to make use of various forms of treatment according to his actual needs. The different forms of health care are looking for ways and means of linking up with one another.

As a result the provision of care and treatment could be built on past treatment and would have to take into account that this intervention may be followed by others. The first question that comes up in this respect is how to organise and fill in the intake procedure in this context.

With respect to the intake procedure, it means that every centre gathers information in the same way, draws up an intake dossier, reports on its assessment of the drug user's problems, on how they tackled them, on what objectives were set and on how far they have been achieved - all in the same way. In order to maximise continuity, central intake points per region are our objective. The day centres will play an important role, for the drug user will have to visit only one place, with the added advantage that he/she will be known there and that he/she will know the place, where he/she will be able to take adequate treatment which will bring about a maximal change. A point in the client's favour is also that his case-story will not need to be repeated before treatment can start; the advantage to those who provide care is that more successes can be achieved.

The outflow of clients can be optimised by working in phases. After the first phase an evaluation of the results with regard to the objectives set, can be made; thereafter, one out of many other possibilities can be chosen, e.g. the treatment can be continued or other objectives can be set, or the original objectives can be aimed at in another way. In order to know what adaptations are needed, we can consult the dossiers in retrospect or information can be gathered by means of a three-monthly evaluation of the treatments. These evaluations are prepared by a written report which can stimulate the updating of the dossiers.

All this will be possible if we develop a methodology for clinical practice. Three important elements of which are: (i)assessment, (ii)design and (iii)evaluation. (i)Assessment comprises the systematic gathering of data in order to describe the client's progress. (ii)Design is the manner in which the therapeutic interventions are carried out. (iii)Evaluation is the way in which the recorded data gathered in the assessment phase is analysed in order to discover interference.

A way of investigation which can inspire clinical practice is the 'single-case' investigation, which was to a large degree developed within 'behavioural research'. 'Assessment' is done by means of repeated observations of what happens in the course of time. 'Observation' before the start of the treatment forms the 'baseline'; it indicates the level of functioning of the client and serves the purpose of forecasting the functioning without intervention. Concerning 'Design': the intervention is generally judged by making deductions based on the different conditions of the client at different points in time. Organising these conditions ourselves, as is often done in experimental research, is hard to reconcile with the ethics of clinical practice.

The data-evaluation should aim at the same objective as that of the statistic evaluation: checking whether the results are consistent and reliable, and whether they are not the result of coincidence.

Kazdin describes visual inspection as a method for data-evaluation. He looks for a concrete application of the above mentioned principles of systematic assessment and evaluation in clinical practice. His priority is the explicit identification of the treatment objectives. Furthermore, fixing the priorities between the treatment objectives and the definition of the size of the change desired, is necessary. Thereafter, specification and assessment of the procedures, processes and means come to the fore. It concerns the method of achieving the objectives. An important element in this respect is verifying whether the treatment was done as required. The processes which the therapist wishes to make use of may come under that heading. The third point consists of the selection of the measures : what sources of information, what methods are going to be used? Sometimes standard instruments can be used (e.g. tests), but it is often necessary to develop individualised instruments. The next point is the time of the assessment. It can be done once or several times before the treatment; in the latter case we obtain an idea about the variance. We may also make inquiries with others, e.g. relatives. The client profits not a lot from a post treatment test. Assessment during the treatment is ideal as part of every session on the basis of tasks which the client has to do. Assessment is best integrated as part of the treatment, and can as such be discussed with the client so that he/she also knows that it is part of the treatment.

During the treatment the measuring can be adapted, e.g. when continuously low scores are obtained when measuring a problem or when another problem turns out to be more important. In that case, the function of the design is also to eliminate alternative explanations of the change that occurred, i.e. to allow for an answer to the question whether the change was the result of the therapy or of something else. The data-evaluation enables us to check whether sufficient change was introduced and whether the change is clinically significant : does the resulting change make any difference to the client?

2.3. Structural Elaboration : the Organogram

De Sleutel comprises various sections: the hierarchic therapeutic community, the psychotherapeutic community 'OvaaP crisis centre and day centres in Antwerp, Ghent, Bruges, Mechlin, Brussels, Aalst and Mol. All these sections have as a target group illegal drug users, but their services may differ: crisis intervention, residential rehabilitation courses and motivation programmes for the crisis centre; long-term, intensive, group-oriented and residential treatment in therapeutic communities; ambulant rehabilitation service, multi-disciplinary consultations and day service in day centres. Among the day centres there are differences because regional needs may differ. This network reached 2500 people in 1994, 1100 of whom were treated by our own network.

Besides these treatment sections, there is a logistics service. Every section is the responsibility of a section-head who takes care of the daily organisation of all aspects of the service, except recruiting and dismissing of staff, training and external relations beyond the region, which are the responsibility of the general director. In addition to the section-head, each section is run by a doctor and a adjunct section-head.

Within the network everybody consults with their peers : the section-heads make up the clinical consultation, the medical doctors have their medical consultation, the adjuncts take care of logistics. These official bodies also have an advisory function with regard to the management committee.

The policy of the network is executed by the management committee. Before going into the responsibilities of the members of the committee, it should be emphasised that every member, except for the general director, has to do primary service in the sections in addition to his managerial tasks.

The clinical director takes care of the co-operation among the sections, checks whether the treatments in the sections are done according to the approved project proposal, and is entitled to take decisions when conflicts arise between sections about treatment aspects. The medical director has similar tasks but more on medical level. The logistics director has corresponding tasks on a logistic, an administrative and a financial level. The general director presides on the management committee. He is in charge of all aspects of the organisation, but delegates the clinical and medical responsibilities to both the clinical and medical directors. It is also his responsibility to keep up external contacts beyond the region, e.g. with other organisations, umbrella organisations, government authorities and the Brothers of Charity. He is responsible for recruiting people with a degree up to Al level and for training and formation. Finally, the operational director is responsible for the concrete implementation of the policy agreed on.

Complementary to the hierarchical line, there is an advisory organ which is called the strategic think-tank. It is based on a double criterion : first, every section has to be represented; secondly, every profession has to be represented. The strategic think-tank. It is based on a double criterion : first, every section has to be represented; secondly, every profession has to be represented. The strategic think-thank combines the knowledge of the network and advises the management committee on the execution of the policy.

Since the merger with the Brothers of Charity, the activities of De Sleutel are followed up by a steering committee. The recruitment of licentiates (university degree) and doctors, the introduction of new treatment modules, setting up new sections, come under the authority of the board of directors.

2.4. Communication, Types of Meetings

Our starting point is the situation in the sections. Once a week there is a section meeting. It is presided over by the section-head, furthermore, there are staff who have internal responsibility, viz. The adjunct section-head, the doctor and possibly other staff members. A report on the past week is delivered and on what is planned for the coming weeks. The section-head reports on external contacts, the situation in other sections, clinical and medical consultation. Decisions of the management committee and of the general director are passed on. The quarterly evaluations are prepared. Short-term planning is done. Every member of the staff receives a copy of the report. If somebody wants a point to be put on the agenda, he/she can do so via the person in charge of the domain to which the point refers.

Once a week there is a clinical meeting. All staff take part. Applications and people who were referred in the past week are mentioned. The objectives of the new treatments are discussed. After three months every treatment has to be evaluated. Problems on a clinical level are discussed.

Decisions are made by consensus. Every three months there is an evaluation of the section. Everybody takes part. This evaluation has consequences for the long-term policy within the section. This policy is also the topic of internal workshops which takes place twice a year.

Another important advisory organ for the development of the network is the strategic think-tank. In this group each section and function that exists in De Sleutel is represented. Members alternate annually so that in the course of time most staff members will have taken part in this body which advises the management committee on the preparation of the marathon sessions of the committee during which the long and medium term strategies of the organisation are planned and evaluated.

The section heads form the clinical consultation group, presided by the clinical director. It has an advisory function with regard to the management committee. There is a consultation every two weeks. It corresponds with the medical consultation at which the GPs of each section meet. The consultation is chaired by the medical director and is a monthly event. The logistics consultation, in which the adjunct section heads, in particular, participate is presided over by the logistics director and is also a monthly event.

These consultations are an opportunity to exchange information about the state of affairs in each section, to discuss points of interest common to several sections, to bring the co-operation between sections to the fore. If there is a conflict, it is discussed, and if no consensus is reached, the chairman resolves the problem. Clinical and medical consultation may lead to advice for the general director. Decisions are taken by the management committee in their weekly meeting. The members are the general director (chairman), his secretary, the medical director, the clinical director, the operational director and the logistics director. The policy of the management committee is implemented in the sections by the operational director. The section-heads visit in turn the management committee.

The street comer workers in the different sections have their consultation every three weeks.

Migrant collaborators have also their regular consultation in order to advise on the development of care which is more accessible to migrants.

2.5 Who makes it happen : the staff

Working as a network has consequences for the internal functioning : how do the staff members see the organisation? For instance, we apply this to the person who does the intake at a given section. The intaker will take into account not only his own vision and the setting of his own section; within the network, he will have to identify with the whole organisation, with the other sections too. In order to achieve this attitude it is necessary to organise frequent contacts between the respective sections as well as to get to know each other better. The intakers have to be informed of the target population, the objectives and working methods of the other sections and of the external centres. They must be convinced of the advantages of co-operation and they have to back it unconditionally.

Job rotation is another way of reaching this aim. An employee will work for some time in another section while he is replaced in his own section by someone from another section. In that way he gets to know and experiences not only the other section but will also bring with him his own input of knowledge and expertise to that section so that both partners increase their knowledge. The available know-how is shared more effectively. Sometimes job rotation can be used to prepare a person for a new job: the employee can learn some skills which he will need in his future job in the section where he will function in time to come.

Working in a network has also its implications for the training of the staff. In addition to short in-service training for specific objectives, e.g. registration and processing of the Addiction Severity Index, there is a general training programme. On the one hand, it consists of courses that every employee takes, viz. the experience practices in therapeutic communities in the Motherlands. On

the other hand, we have the more individualised staff practices in diverse centres, mostly abroad, where the employee gains experience specifically meant for him. Taking longer psychotherapeutic courses is also encouraged. For section-heads there is a specific two year course in the management school of Guislain Vormingscentrum, Ghent.

In order to facilitate the transfer of information from one person to the other, an agreement must be reached about what information is wanted and where it is found. Agreement must be reached about how this transfer is done. The theoretical development of both the intake and the treatment model is not sufficient; it is our purpose to apply the system. Therefore, training of staff and supervision of their work are a must.

The organisation is growing considerably. New centres are mushrooming and there is a parallel increase of the number of staff and there is a great need for training of relatively inexperienced employers. A staff brochure is available for the guidance of new staff members. These people have to be trained in general but also in doing the intake and drawing up treatment programmes. We cannot wait till all phases of the process of change have been gone through; it will take some time before the end result is reached. Meanwhile the work must be done.

2.6. Follow-up of the support of the network

The organisation also consists of a number of projects which support the whole, these projects are united in one scientific cell. This group develops the registration system and takes care of the processing of the registration data of the whole network. Their task is to do the scientific follow-up of the treatment and to provide feedback to the sections. They also evaluate the effects of the projects : lectures, Sleuteltrains and neighbourhood prevention projects. These are projects which De Sleutel enriches with its know-how and experience in order to link them in a useful way with the prevention projects.

Conclusion - Development of a Network is a never-ending Process

The development of a network for the care and treatment of drug users reflects an evolution in the way of thinking about the role of several interventions in the processes of change. Because of the chronic aspect and the complexity of drug addiction, a single intervention seldom produces a lasting solution. In order to maximise the effectiveness of the respective interventions the latter are at best connected. It should have its consequences not only on a clinical level but also on the whole organisation. In 1995 this process of change is still on-going in De Sleutel; all implications are probably not yet known. At any rate, we are convinced that, in the interest of our clients, we will keep to the course we have embarked on.

END.

(See Appendix Number Three for "Components of the Network" - A description of the different services and activities of De Sleutel)

"A network is more than a collection of separate entities..."
–Annemie De Loose

Jack Houlahan

Care in The Community: Are People Really First? An Overview from Northern Ireland: Pointers for the Future

Introduction
From Griffiths (1988) to Community Services Charter (1995)

Although the notion of 'care in the community' goes back to the 1957 Report of the Royal Commission on Mental Illness and Mental Deficiency (HMSO 1957) which recommended that patients 'fit to live in the general community should not 'be in large or remote institutions', it is with the Sir Roy Griffiths' Report on Community Care (HMSO 1988) that the actual shift towards care in the community began to happen.

The target population for community care is the group composed of 'the elderly, the mentally ill, the mentally handicapped, the physically disabled'. In Britain and Ireland people with substance misuse problems have been placed within the group of mentally ill; the management of their treatment has been the responsibility of medical psychiatrists within the hospital system.

Griffiths begins from a general management perspective and the belief that cost improvement is at the heart of any management process. Cost improvement is created by good policy and efficient execution. His main recommendations were for the appointment of a Minister of State responsible for community care; a 60:40% division between local and national government of the funding responsibility; that local government assess needs, set priorities and develop local plans; that the delivery of services should be on the basis of individualised 'packages of care' from 'an identified carer'. Finally, he carefully distinguished between the functions of designers, organisers, and purchasers of care and these distinctions have become a characteristic feature of the new arrangements.

Along with his actual recommendations Griffiths envisaged the emergence of a new profession of 'community carer' whose function would be to put together the individual's package of care at local level. This new profession has not materialised, nor has it been encouraged. And while he strongly advocated co-operation and co-ordination between the statutory and voluntary sectors, his report contained no suggestion about how this co-operation (which has been an ongoing and major source of inefficiency and waste of resources in the British system) could be brought about.

As Britain under the Conservatives quickly moved to the creation within the NHS (and the BBC-lest we should think that only the Health Service was affected) of internal markets, general management, quality audits, and the basic purchaser/provider division as a principle for operating health services, a number of the ideas of Griffith were taken forward in the Government White Paper, People First(HMSO 1990)

The Basic Philosophy of 'People First'

The starting point for People First is the belief that 'services should intervene no more than is necessary to foster independence'.

Assessment of need is clearly the cornerstone of this approach, as is the idea that the funding should notionally 'follow' the individual. Funding to local Health Boards is therefore on the basis of population size, age range, sex and local patterns of morbidity.

The new 'Purchasers' (in GB the Local Authority and the Health Boards, in Northern Ireland the Health Boards and the Northern Ireland Office to whom the Local Authorities lost their powers) are exhorted in the strongest possible terms to create a 'flourishing independent sector' and a 'mixed

economy of care' to provide the individual with the greatest range of choice and to encourage competition among services.

As with Griffith, however, beyond exhortation there is no indication of any specific measures to bring about the mixed economy of care.

Highlights of 'A Mixed Economy of Care'

The following lists contain the main features of this ideal blend of care and allow us to **see some** potential in People First.

Purchasers

- Implement government policies and health targets
- Assess overall need and develop a strategy
- Buy a range of services from both the statutory and the independent sector (the new name for the private and voluntary sectors taken together) according to criteria of quality, choice, access, effectiveness, value for money....
- Monitor and continue to evaluate effectiveness and assess need

Providers

Tender for and offer under contract a range of health services according to Board specifications Sell services to GP Fundholders, to private health insurers and companies, to other fundholders (i.e. other Trusts who don't have a particular speciality) Provide these services independently or through subcontracting and other forms of partnership Employ staff, own property, provide training and research and professional education and generate income

The Individual

- Is individually assessed and should receive a 'package of care' which matches the assessed need and reflects the individual's concerns and preferences
- Is relating to another named individual who has overall responsibility for their care (the named nurse, the named social worker...)
- Has a Charter which sets out what services they are entitled to, acceptable time constraints on delivery and avenues of redress when not satisfied

At this point I would like to emphasise what I believe to be a central issue both now and for the future. Prior to this division between purchaser and provider the assessment of health service needs, although not clarified as a core task, was carried out in the ongoing dialogue between the mix of managers and professionals who made up the Boards. The primacy in these dialogues was with the professional judgement and there were always financial constraints and priorities. Research was mainly carried out by the providers, often at the point of delivery and new trends in service provision or the management of its delivery (e.g. the shift from emphasis on in-patient residential care to out-patient and brief interventions for addicted people) came about through the development of a professional and research consensus which in turn influenced the managers and policymakers.

The new system breaks this pattern of assessment, introduces stronger competition between providers -often for a diminishing allocation of money- and introduces elements of secrecy round the development and protection of new ideas. Industrial espionage enters the Health Service. The potential dangers to the objectivity of research are obvious, as is the potential for serious imbalances in the delivery of services for those with a substantial amount to spend on services and those with a fixed or diminishing public allowance for care. Such a system could have negative effects on the development of the long-term strategies needed in the field of substance misuse, and

on our ability to provide the broad range of flexible and adaptable services the desirability of which current research would seem to demonstrate (Alcohol and The Public Good, WHO 1994).

What Happened?

By 1991, when the government body newly formed to oversee the introduction of the new arrangements for the NHS, the Social Services Management Executive, produced its HSS Trusts: A Working Guide (HMSO, Belfast, 1991), the lines of current development were becoming clear.

The Health Boards which previously had planned, developed and delivered all the care beyond that provided by General Practices and Health Centres were now divided into a central assessment of need, strategic planning, and purchasing role, and a series of provider trusts, with their own independent management structures and finances, some of whom could become purchasers and sub-contractors in their turn.

The new trusts have formed as natural consortia of related services (e.g. Hospital Trusts, Social Services Trusts or Community Trusts, Trusts as conglomerates of services with particular areas (e.g. Sperrin-Lakeland, South & East Belfast Trust).

Care in the community becomes 'existing statutory services moved to the community

Because the checks and balances which the co-existence of Local Authorities and Health Boards in Britain provided did not exist in Northern Ireland, our Health Boards had the whole responsibility for dividing themselves into purchaser-provider functions and for setting up the new mixed economy of care. The first rush of competition pitted the voluntary and independent sectors against the statutory sector and with the Boards in control there was no question of them passing over those services they had previously managed. They also forced the voluntary sector to behave much more like any capital intensive business.

In Northern Ireland the only new players were the GP fund-holding practices, but even now they are not allowed to purchase non-statutory residential treatment services for their patients.

At the same time, the interpretation put on 'Care in The Community' by the Boards was not to think about resourcing communities (assuming them to have been defined and assuming them to exist), but simply to transfer hospital-based and other statutory services (now in the form of Community Mental Health Teams, Community Addiction Units and the like) into particular communities. Consultation with these communities was about the siting and security of those services which made communities nervous (mentally ill patients, known paedophiles, etc.).

Voluntary services and new community-based approaches which were springing up alongside the traditional mix of approaches sought the opportunity to 'tender' for the new range of services but the first run of contracts with providers were all with the statutory side. Only those services which provided accommodation for rent by the main services, or those which provided a completely ancillary service (e.g. the befriending groups devoted to the mentally ill in the community) attracted contracts in the first instance.

A Current Example

In 1995, my own Western Health Board area of Northern Ireland brought out a document called The Community Services Charter. It identified the priority target groups for community Care as follows:

- Those coming out of hospital
- Those living alone or at risk
- Those living with an elderly or disabled carer

- Those who are terminally ill

It also identified four groups of professional carers**;**

- Nurses, Midwives and Health Visitors
- Personal Social Services (including child protection, etc.)
- Family Practitioners (GPs, dentists, opticians...)
- Physiotherapy, Occupational Therapy, Chiropody, Speech & Language Therapy...

From these groupings we can see that there is no official recognition yet of the range of skills which may be developing or which may be easily developed within communities to meet their own needs, nor is there recognition of the potential of communities to analyse, assess and respond to their own health needs (as many have been doing for years because of the poverty or irrelevance of mainstream healthcare).

Packages of care - whose packages?

Apart from the general assessment of need, problems have also arisen at the level of individual assessment. In addiction services, for example, if an independent sector agency has a contract to provide X number of individual treatments each year, does the agency itself do the assessment or is that carried out by the new assessment teams which area springing up? If the latter, how do we ensure that these teams contain the necessary skills to 'match' individuals with treatment (a skill for which no criteria other than experience presently exists)?

By the same token, the new competitiveness militates against the sharing of information and development of 'case management' approaches or co-ordinated interventions. It benefits agencies to count heads separately and maximise caseloads to justify traditional patterns of funding.

The EU: The Impact of Structural and Delors Funding

The biggest effect of European Funding on Northern Ireland has been the emergence of Area Partnerships. These are having an increasingly significant impact on both rural and urban life, especially on the effort to put in place shared infrastructure and technology, and to co-ordinate development according to shared criteria and shared goals. Until a peace settlement takes place and funding power is devolved once more to independent Local Authorities, the new Area Partnership provide the one significant counterbalance to Health Boards and Trusts to have emerged in Northern Ireland.

One of their impacts has been to channel a growing pool of talent at the community level, talent that has been stimulated by a whole raft of independent community self-help programmes which have been growing slowly over many years, and by the growing number of formal community development courses and qualifications. Within the new Area Partnerships community-leaders and community-workers take their place alongside the representatives of the business community and the local authorities to develop Area Development Plans which now include healthcare and prevention programmes as a matter of course.

Boards are now having to consult such partnerships around the issues of needs assessment and service planning, while independent sector agencies have begun to approach partnerships with ideas for projects which are seen to fit within the overall development plans. The possibility now exists of:

- Co-ordination by Design
- Independent projects by Area - Drug Action Teams, Co-ordinators not 'nominated' by Health Boards
- Independent Assessment of need
- An Alternative approach to prioritising Health and Social Care

- A way to clarify what 'Community' means
- A way to harness Skills within Communities

What Next?

I see a process going in two directions between all of the following:

UN, WHO, EU, GOVERNMENT, DEPTS. OF HEALTH, AREA PARTNERSHIPS, HEALTH BOARDS, PROVIDER SERVICES, COMMUNITIES...

I see the need at the highest level for a set of policies about 'substance use and misuse' above and before policies about particular substances like alcohol, tobacco and other specific drugs.

I believe that at regional and local level the purchasing power of government (which hasn't changed and which has the political option to adjust) could be used to create real co-ordination of services, programmes, training, research and evaluation.

I believe that given an equality within a tendering system, services and agencies could be made to see the financial advantage of combining to 'sell' co-ordinated services. All parties should work to ensure that the proper range of those services is put in place,

Information technology and case management could be improved to increase the efficiency, adaptability and relevance of those services.

Finally

Many years of witnessing the difficulties of effecting any significant structural or organisational change, however, lead me to temper hope with a caution, and a final list of my doubts and concerns include:

- The fear of political ideology (which forces its dream on the minority and refuses to see its faults)
- My fear that fixed sums of money do not create flexible, adaptable services
- Can purchasing bodies develop financial incentives and strategies to stimulate co-ordination?
- Can competing agencies learn to co-operate?
- Is there the political will to confront the real face of substance misuse- the serious personal destructiveness of the consumer-culture?

The new matrix for treatment is not the 'sick person' or 'the addict'; it is the matrix composed of Society-Substance-Social Group-Person. Our only hope of tackling such a mammoth task is by finding innovative ways of making major systems work together.

END.

'...There is no official recognition yet of the range of skills which may be developing or which may easily be developed within communities to meet their own needs, nor is there recognition of the potential of communities to analyse, assess and respond to their own health needs..."
–Jack Houlahan

Peter Steen Jensen

"Visions from the City of Odense's Municipal Department 5 (Children and Youth): Concerted action on child development - with special focus on prevention of drug abuse."

I am invited here because in our city the politicians some years ago decided to reorganise the total system. I am with the 5th Department of Children and Youth. I will explain:

- How we are organised
- What are our aims
- What are our successes
- What are our failures

If there is time I will talk about drugs prevention with our young people.

This morning has been extremely interesting for me. If I could start with Minister McManus's speech. She said that she believes that we could win the battle against drugs. I'm not so sure of that. What we try to do in Odense is that we try to start with good possibilities for children to develop properly. We feel this is the best way to prevent drug misuse. Minister McManus also said there are territorial fights within different departments. It is for this reason, that the government in Odense decided to reorganise, so that instead of in-fighting we could have co-operation. Minister McManus said one of the problems in Ireland is that perhaps Irish institutions think they are part of the solution to the problem, but instead they may be part of the problem. On this point, I totally agree.

After travelling around your city and seeing Dublin's progress, you maybe think that you are part of the solution. In a way you are old fashioned, you think of children as they were 20 years ago. The reality is they are totally different. You have to remember that not only has society changed in the last twenty years, but children have also changed.

Although Ireland has very different background and customs (and those are important to take into account), I hope you will be able to benefit from what I have to say. It is worth noting that there were some very important points made here this morning. Pat Dolan talked about Social Networking. When a child does not act in a way we think he/she should behave, then we carry out an assessment or find an expert. We then take a young person away from his/her parent or perhaps return to same parent. Doing things in that manner, we will solve nothing. We must focus our efforts on ourselves, our homes, our schools, our institutions and in our every day life.

I have recently read a very important report and it goes very much along the lines of Pat Dolan's presentation and research. It states we should get to know children (with problems) as early as possible and we should try to identify the signs they are showing in order to get children the help they need. In the report, it stated that 15% of our children are at risk. It is interesting to note that if you follow them through their lives 50% will turn out fine. That is without us doing anything. The other 50% will have problems. So what can we do? Do we do nothing? Do we do something and hope that we don't do further damage? As a former teacher, I wonder now if the students learned because of something I did or was it because I didn't do something?

In that same report it states children need three things to succeed:

1. Social Networks
2. The skills and ability to foresee situations and make choices
3. Self-Esteem and Praise

As policy makers these three elements should be at the top of our aims in our schools, institutions and all areas where we work with children. We are first of all people who work with children and then teachers, youth workers, counsellors, etc. That is what I learned today.

The City of Odense has a population of about 200,000. It is located on an island in the middle of Denmark and the city is located in the centre of the island. We have a big harbour. We have a centre for communication and transportation, a centre for trades, we have a University and a Technical High School, etc. We have all the things that would make us be a big city including all the problems, drugs, criminality, etc. We also have a growing minority of non-Danish speaking people, including schools where the majority of students do not speak Danish.

In order to respond to these problems, the politicians decided some years ago that we would have to change. We would have to focus on the children and not on the infrastructure and industry. Ensuring that our children would be given the best quality of services would be our new priority. A new strategy of self government for all institutions was undertaken.

We have different ways of doing things in Ireland and Denmark I write *state, county* and *municipality,* that is because we have three levels. As a citizen in Denmark I pay tax to the State, the County and to the Municipal Government. When I talk about money, I don't talk about being funded by the government or the county or somebody else. I am talking about having a budget every year from the city, from the municipality. We enjoy the right to have a good budget every year.

This is the organisation of our Department, Deputy Mayor, Manager and then various departments totalling 5,000 in our Department, (**see Appendix A - Municipality of Odense)**

The overall aims of Department Number 5 are as follows:

> All activities are to be co-ordinated and integrated at all levels, and organised on the basis of an all-embracing solution. I totally agree that if the users do not feel that the activities are integrated then it is not integrated That means from the political levels and through the institution level.
>
> The starting point for activities must be the individual child and it's environment.
>
> As far as possible, special activities must become part of the system. As far as possible we have aimed not to take children out of school out of the class and make special treatment for them somewhere else. We keep them in the normal system and work with them there.
>
> Furthermore, preventative work must be reinforced within the normal system. That would include drugs, criminality, etc.
>
> Continued development of self-government and self-administration. All our institutions are self- governing. Each department has a budget and they can use this budget for teaching children or taking care of children, they can engage teachers or pedagogue They can build a new house if they want or buy computers. They can borrow money or save money for the next year.
>
> Including further development of co-operation between self-governing institutions.
>
> The overall activities of the department must be carried out on the basis of openness and transparency. That's a nice aim, I know, we try to do it by informing our politicians every second week we have a meeting with them.
>
> This includes sharing a high level of information with our politicians.

A high degree of quality and efficiency must be secured in: Education, Child care, Leisure activities. Special activities.

Those aims are what we are committed to in City of Odense's Municipal Department 5 (Children and Youth).

With young people there is a triangle of responsibility between the pupils, home and school. Parents must realise, as do schools, that children are not the same as they were 20 years ago. As far as drug prevention, we are talking about two types: *general* prevention and *specific* prevention. The schools and youth clubs are responsible for teaching the children about drugs, alcohol, and cigarettes. The "Drugs Don't Fool Yourself campaign is co-ordinated at all levels dealing with youth. Specific prevention is aimed at high risk groups and risk situations. The focus of specific prevention focuses on not only those at risk, but also the professional personnel in the classroom. These professionals are the ones that see the children daily and would notice changes in the children's behaviour. That is why they must receive training. We like to have at least one teacher per school responsible for drugs education. We also provide training for Social Workers and Street Workers who deal with high risk groups.

The problems with drugs education are the same all over the world. Drugs Education is *in* the curriculum, but it does *not* have its own time allotted or classroom or teacher. Therefore, we have to make someone responsible for it. Someday, I would like to see the children brought to where the drug treatment/rehabilitation happens and have a classroom there. That is when real learning will take place.

In conclusion, we have to tried to make Odense's response a co-ordinated one and under one Department. In this we have succeeded. We have also had success in changing the attitudes of the our citizens, teachers and policy makers. I wish Ireland the best of luck in your attempts to co-ordinate services for your young people.

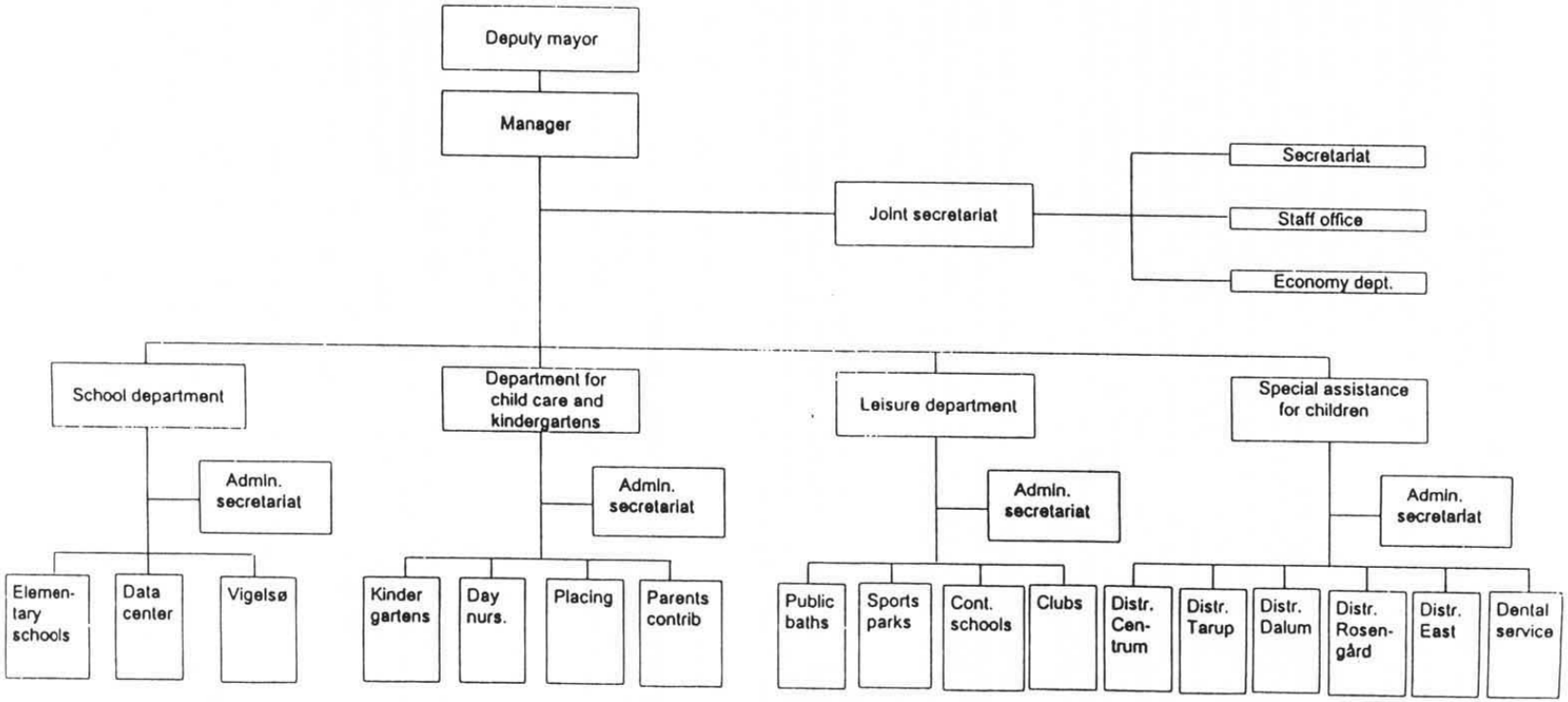
END.

(see **Appendix B - Integrated Organisation for)**

"...We try and start with good possibilities
for children to develop properly.
We feel this is the best way to
prevent drug misuse."
–Peter Steen Jensen

Municipality of Odense
5th Department
The Department for Children and Youth

Odense Municipality, 5th Department - The department for children and youth



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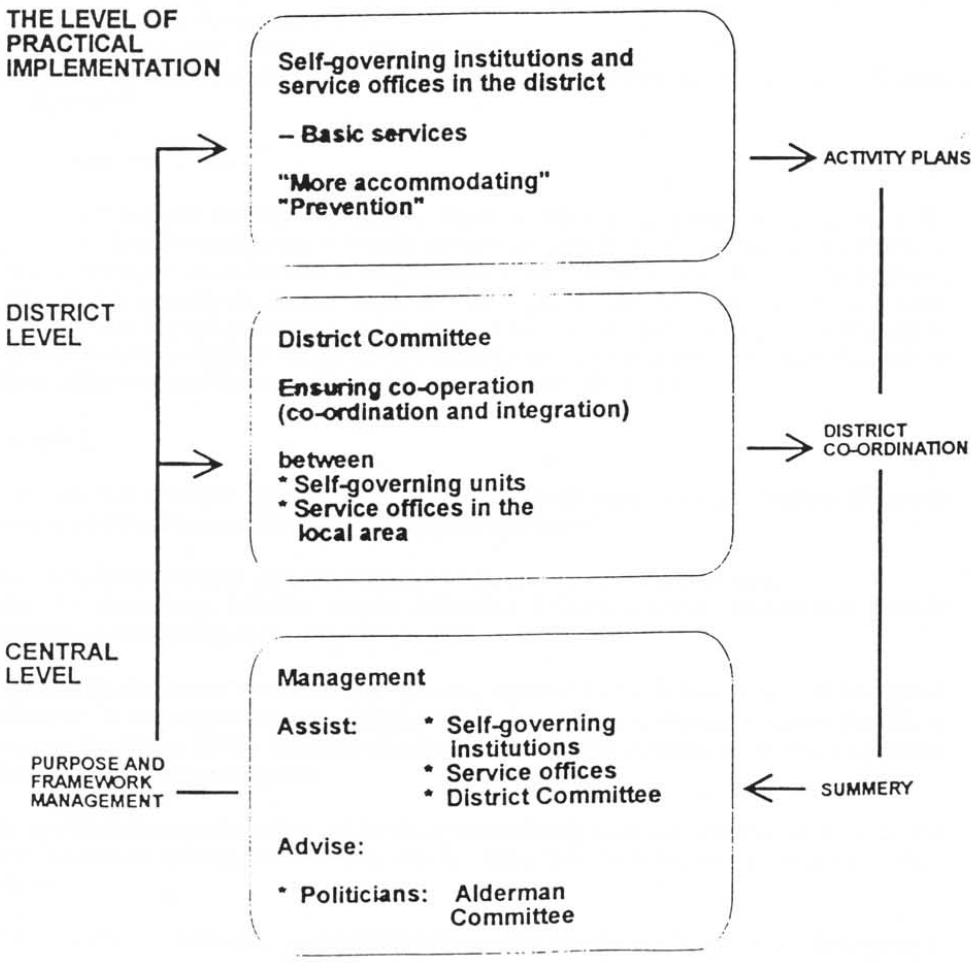
Appendix A (Peter Steen Jensen)

Municipality of Odense
5th Department
The department for children and youth

Integrated organisation

for

The co-ordination and integration of all levels of activities on behalf of children and young people



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WORKSHOPS

There were six separate workshops run in the afternoon. Each workshop had a facilitator, and a facilitators assistant provided by the Ballymun Youth Action Project. In each workshop there were approximately 18 participants.

The workshops tried to be three things: *Informative, Explorative and Participative.* They tried to be *informative* by providing a case study for the group which will give them an insight into some of the complicated aspects of an individual's or community's drugs problem. They tried to be *participative* by the style of the facilitator who sought to draw out the knowledge and expertise already in the group and encouraged the participants to apply it in responding to the case-study. They tried to be *explorative* in setting a task for each workshop group, a task which they have to apply their own fields of expertise to and discover what they can effectively do as part of a Joint Systems Response.

The participants were asked to do the following:

1.) Read a case study (see below) which focuses the attention of the group in looking at their roles as part of a Joint Systems Approach.
2.) Reflect on how they could be of help in relation to the case study.
3.) Identify possible changes they could make in their roles to become part of a Joint Systems Approach.

Case Study One : Rita

Rita is a 19 year old girl who is pregnant. She is in regular contact with her doctor due to the pregnancy. People (family, doctor, friends) are worried about Rita and fear that she will become a regular drug user. This is because of the environment she is living in. She lives with her boyfriend who is an I.V. drug addict, Rita has a family living in the area and is in regular contact with them. Rita has been in regular contact with her doctor who has been prescribing her tranquillisers to relieve her anxiety problems which she attributes to living with a drug user. Rita regularly drinks at home, alone, on top of the tranquillisers - she says this is to help her sleep.

Feedback:

Questions and concerns were raised around the following issues for Rita: Medical (Pregnant) Boyfriend (Drug Services) Doctor (Prescribing Tranquillisers)

Other key issues included: different organisations have different ways of working;
facts vs. assumptions; labelling people; differences between voluntary workers and statutory workers; statutory obligations; reluctance to shift.

Specifically the Doctor's conduct was question, especially around prescribing and monitoring practices. It was agreed that the relationship with the GP was an important contact for Rita to remain. Besides the GP the workshop also focused on outside groups that could play a supportive role for Rita, including her family.

It was felt that because both Rita and her family were already in contact with various services. The key concerns identified by the workshop were for: baby, Rita, boyfriend, environment, GP, and her family.

Other practical interventions were highlighted including helping her family or concerned person; equipping her support network with the skills and the knowledge to be able to deal with situation; trying to get Rita to join an NA or another such group. Also the welfare of her baby was

emphasised, including: pre-natal care through GP, linking with ante-natal clinic, and linking in with a social worker.

Ways were identified to enhance the working together by various group. They are as follows:

- both voluntary and statutory agencies need to share information, honestly, and with sensitivity
- liaising with each other
- learn more about each other's structures
- recognise limitations
- major issue arose concerning the GP's prescribing
- GP must be made aware of counselling services available locally
- Responsibility on other agencies to make their services available
- we need to look at studies carried out in other areas and stop being subjective in our own areas.
- professions need to be less territorial, more accountable
- link between drug misuse and high suicide rate among young people.

The following problems were then highlighted: difficult to put so much time and energy into one person, programmes often number focused, large waiting lists.

Case Study Two: John

John is an eighteen year old who is just finishing an apprenticeship as a chef. He has been a "recreational drug user" for a couple of years. John has just been arrested for possession of three Ecstasy tablets. This has been the worst incident so far of John's drug use although he has dropped out of sports/social groups he was attached to, he has changed his circle of friends, he is on a last warning in his job for absenteeism. John still lives with his family who are beginning to notice some changes in John.

It was accepted by the workshop participants that the following course of action should be taken in regards to John. First, John should be presented with his choices, emphasising that the he is responsible for his own actions. Possible consequences of his actions should be explored and the process should involve significant people in John's life.

In order for intervention to be effective, agencies should adopt a *Joint System Policy*. Drug specialists should also be involved in supporting John's network. Other themes also emerged from this workshop and they were as follows:

- All relevant services should be involved
- Strategies should focus on the individual and those surrounding the individual
- Training needs were highlighted
- Policy and role clarification must take place within

Again difficulties in working together were highlighted, such as:- resources, high case loads, rivalry, different philosophies.

Case Study Three : Monica

Monica is a teacher who teaches a class of 14 year old girls. She is very worried about a group of girls in her class. Recently their behaviour has changed for the worse. They are often absent. They have become very negative in their attitudes and approach to Monica and the other girls in the class. Other teachers have complained about their behaviour. They frequently make references to their use of drugs. One girl seems to be at the centre of things - Martha. Monica knows that Martha is living in regular exposure to drugs and that her brother and sister are opiate users. So far discussions with Martha's Mother have been less than helpful. The girls don't seem to be part of any organised youth groups in the area.

The initial brainstorming of this case study resulted in a medical/social approach being taken - the holding of a case conference, the identification of key workers and possibly involving the child psychiatric service in conjunction with whatever voluntary youth services were available.

However, this approach had a ripple effect on the different disciplines participating and many other issues and possibilities arose. These included, for example, the necessity for a child-centred approach and identifying the real issues and problems behind those being presented. Solutions suggested involved working with Monica herself, not only by encouraging her to explore her relationship with Martha, but by opening it up to the whole class, through setting essays with carefully selected, relevant topics; working on self-esteem within the class; as well as utilising drug awareness programmes for teachers, by contacting an agency such as YAP, to promote both primary and secondary prevention of this problem.

Also noted was the importance of contacting Martha's mother, perhaps through a Home School Liaison Co-ordinator, to explore the family situation, the presence or absence of a father, and what, if any, professionals are already, or have previously been, involved.

Gradually, it became apparent that the case could, in fact, be broken down into different strands in order to facilitate working on the problem. For example, looking separately at Monica, Martha herself, and Martha's mother. From this angle, an abundance of solutions and possibilities began to suggest themselves and from which it became easier to sift through, select the most appropriate, and finally, to link together at the end.

Hence, some of the solutions highlighted were as follows:

- Monica could express her concerns to Martha and offer someone to talk to, i.e., indicating she actually cares what happens to her; furthermore to bring her concerns to the attention of the other teachers to ensure Martha does not become a scapegoat.
- Opening up classroom dynamics through role-play, dramatisations, etc., or perhaps even through a school "adventure weekend".
- Using the introduction into schools of the new SPHE (Social, Person, Health, Education) programme to tackle the drugs issue more directly and openly.
- Introducing programmes for children and parents and promoting trust and communication between parents and schools. Here a pertinent question was what management structures needed to be in place to allow for this? This further led to:
- Promoting a clear, open policy in schools for dealing with such problems, with known and accepted procedures. The importance of representation from the local community, Gardai, parents and teachers were especially highlighted here.
- Finally it was noted that Martha's mother may be so weighed down with addiction problems that she may be unable to offer or even accept assistance. In this situation it was suggested that a Home School Liaison Co-ordinator be involved, perhaps to help work on the mother's self-esteem, or that she be linked in with agencies such as NAR-ANON.

Many more suggestions were offered, and it would be impossible to include them all. However, when it came to summarising and recapping on what had been discussed, it was found that, in actual fact, the main emphasis had been on relationships.

In conclusion, it was felt that the cultivating and maintaining of relationships with young people was a key point in dealing with the prevention of drug misuse. The workshop participants agreed that it was important, as professionals, not to get so caught up in one's own individual job or agency. As professionals time must be set aside to co-operate on behalf of Ireland's young.

Appendix Number 1

Acknowledgements:

URRÚS would like to thank the following people for there participation in the conference:

Speakers: Ms. Liz McManus,

Minister of State at the Department of the Environment, with special responsibility for Housing and Urban Renewal.

Mr. Robbie Gilligan, Head of Social Studies, Trinity College

Mr. Pat Dolan, Co-ordinator of Adolescent and Family Services, Western Health Board

Ms. Annemie De Loose, Head of Department of the Daycentre of Malines, Belgium.

Mr. Jack Houlahan, Director of Training, Northlands Institute, Derry, Northern Ireland

Mr. Peter Steen Jensen, General Manager, Odense Kommune, Denmark

Chairs: Mr. David Treacy, Director, Comhairle Ie Leas Oige.

Mr. Chris Morris, Assistant Principal**,** Probation and Welfare Service.

Ms. Brid Clarke, Director of Child Care and Family Support Services, Eastern Health Board, Dublin

Workshop Facilitators:

Ms. Audrey Kilgallon, Addiction Counsellor, National Drug Treatment Centre, Dublin

Mr. Chris Murphy, Director, Drug Awareness Programme, Crosscare, The Catholic Social Service Conference, Dublin

Ms. Marion Packard, Senior Counsellor, Community Alcohol Services, Tallaght

Ms. Siobhan McGrory, Health Education Officer, National Youth Council of Ireland, Dublin

Ms. Ruby Morrow, Psychologist, Department of Education, Dublin

Ms. Brid Burke, Co-ordinator Family Support Services, Community Response, Dublin 8

Appendix Number Two

About the Hosts

URRÚS - Ireland's Community Addiction Studies Training Centre was founded in 1996 by the Ballymun Youth Action Project to provide training in relation to drug abuse. The aim of URRÚS (Irish for strength/confidence) is to establish a centre of learning and excellence where people can access a range of training options aimed at increasing their effectiveness in the are of responses to drug abuse.

The Ballymun Youth Action Project (YAP) was established in 1981 as a community response to drug abuse in Ballymun. The Ballymun Youth Action Project offers a range of services on all aspects of drug abuse, ranging from work with individuals, families and groups. The Ballymun Youth Action Project also provides education and training in relation to drug abuse. As a community response, YAP is guided by the needs of individuals and families suffering the effects of substance abuse and by the needs of the community as a whole. YAP follows the principles of community development and responds to addiction in the context of the environment in which it is occurring, and promoting local participation at all levels of responding. The Ballymun Youth Action Project believes that:

- **Drug addicts can and do recover**
- **Families do not have to cope on their own**
- **The local community is the most effective place for recovery**

Appendix Number Three

"Components of the Network" - A description of the different services and activities of De Sleutel)

The Day Centres

The target group of the day centres comprises of illegal drug users and their **close** environment (family, partners, friends) who have problems with the use of drugs. Therefore, the centres have a low threshold, for one of their priorities is that a given drug user should be able to find the centre which suits him at that point in time.

The day centres have the following objectives:

- Making contact with drug users and their environment
- Providing information
- Discussing the appropriate way of addressing the given problem in view of a drug-free reintegration into society
- Offering an ambulant treatment programme
- Providing an adequate referral if necessary

Giving us a ring to make an appointment is standard procedure. The intake comprises mostly two or three sessions during which client and intaker search for the right answers to the needs. These sessions take place with social workers, psychologists, nurses, doctors. An Addiction Severity Index is made. Within the network of De Sleutel and their own region the day centres function as central intake units. That is why they fulfil an important role in the network. They follow up a client during his rehabilitation course; they know how far the treatment has been taken and what was successful or not; therefore, they are in the ideal position to lead the client onwards.

Most day centres have a street corner worker. Street corner workers are people who belong to the 'milieu' itself, not **from a** treatment perspective but from an acceptance perspective. They make contact with the drug user in his own environment : cafes, at home, at events, in the street. If the drug user asks for help, the street corner workers give him support and guidance. De Sleutel developed a "Drugs & Discos" project, which became a national project within the framework of the general programme of the Ministry of the Interior. The workers concentrate on discos and similar places for a year to find out what can be done about the recreational drug use.

Our own services in a day centre consist of:

1. Multi-disciplinary sessions
   These consultations may take place once or more times per week. Successful treatment of drug addicts presupposes the application of more than one approach. Therefore, the working is multi-disciplinary: there are medical, psychological and psycho-social consultations. In this way one can work with the individual client as well as with the system.

2. Parents' group
   There are regular meetings in the evening for the parents of drug addicts to help them live with the fact that they have a drug-addicted child.

3. Day treatment
   There are two group-oriented day programmes available:

   3.1. The standard day programme

   Conditions to participate in it are that the home situation is somehow

stable, that there is reasonable hope that the client can break with the habit, that he can look after himself to a certain degree and that some social network is available. The treatment is mostly done in groups in the following way:

Budget guidance, cooking, problem-solving training, relapse prevention, finding new fields of interest, group sessions. The group pays attention to being and remaining drug-clean, to stimulate the participants in their search for another type of behaviour and to give it a go.

The focus is on experiencing their own responsibility and independence; therefore, the emphasis is on life after the treatment: Financing, housing, school, employment, leisure and social contacts. The family is also involved.

3.2. A group project that functions as a motivational space.

This is the place where drug users will stimulate and motivate one another through their drug-free contact with one another. It is done by way of structured coffee-parties during which the target group members meet one another in a drug-free environment. This environment is governed by a few regulations. The rules of the games are, for instance, not to be under the influence, not to talk about drugs and their use, not to make deals, no verbal or physical aggression. Some training activities follow the party.

4. The ambulant rehabilitation courses

A physical rehabilitation treatment can be taken with the ambulant service. Heroin-addicted clients can be helped with medication: methadone. If, however, the rehabilitation treatment consists of nothing more than administering substitute medication, recidivism will occur. For this reason we want the ambulant rehabilitation to be always concurrent with multi-disciplinary consultations or day treatment sessions.

5. Guidance centres

Long-term substitution medication can be administered to heroin addicts who, after evaluation, seem to be incapable of future change. The administration is done in combination with less in-depth but continued and multi-disciplinary guidance. The group is treated in a separate place.

6. In some day centres a drug telephone service functions during working-hours.

Crisis and detoxification centre

The target group of the crisis and detoxification centre (CDC) is made up of men and women of up to 45 years, who face addiction problems and additional secondary problems from which there seems no way out so that they ask for short residential first aid. Their need generally arises in an acute crisis moment. The centre will adapt to that and specialises in direct intake night and day.

There are a limited number of counter-indications. Agreements with general hospitals were made to refer these people to them for a more appropriate referral.

The counter-indications are:
- the threat of acute suicide
- psychotic surge
- perilous condition

Concerning the specific intake procedure, we must bear in mind that before any intake discussion takes place the client him/herself is supposed to contact the CDC, for intake at the CDC is done on

a voluntary basis. Even if there is external or judicial pressure, the client must at least apply personally.

An application for an intake is followed up by an appointment for an intake discussion at a set date and hour, generally on the day of the application. Acute crisis situations which require immediate intervention and which can be handled from within the CDC setting, can be addressed on the spot, night or day, round the clock.

Some clients have already gone through an intake procedure at a day centre, in that case, the procedure in the crisis centre is limited to a short introduction.

If this is not the case and if the client has not enough information to make an intake application an information talk can be arranged. During this talk the client is assessed whether he belongs to the target group. If both the client and the social assistant of the CDC agree on admission, the doctor is consulted. The doctor will either give his permission for admission or he will not.

People can be admitted to the CDC to achieve one or more of the following objectives:

- Acute crisis admittance
- Physical rehabilitation or recuperation
- A short observation of one week
- Advice on further treatment
- Referral

Thus, the crisis centre offers a range of possible services. That is why it takes central place with regard to both inflow and outflow.

The CDC uses many group-oriented methodologies in which the behavioural approach plays an important role. There is both individual and group guidance. Consultations with the family and possible partner of the client also take place.

1. Crisis group
   On the client's arrival at the CDC, he is received into the crisis group. The first aim is physical rehabilitation under doctor's control. The CDC staff, together with the client, acquire insight into his problems. Therefore, the client will be asked to write down the story of his/her life.

   As soon as possible a monitoring staff is appointed who will take charge of the individual guidance of the client. This person is the one who will be approached when difficulties arise or when private business has to be discussed.

   The crisis phase ends if the following conditions are fulfilled:

   - physical rehabilitation has been achieved
   - the life-story has been completed
   - the staff are of the opinion that the client is able to join the motivation group

   The client's stay can also be concluded after physical rehabilitation if that was the agreement at the time of the intake.

2. Motivation group
   Motivation means that the client is willing to find out, together with the staff, what the problems are and what can be done about them. We expect the client to take part actively in the chores and the organisation of the day activities. The rule is that one co-operates. The actual situation matters. The basic idea is not to throw in the towel. The client has a chance to create order in his/her life and to search for ways of addressing his/her problems.

The day programme consists of group discussions, individual consultations, creative activities, sports, cultural outings, seminaries, recreational activities and household chores like doing the laundry, ironing, cookery and cleaning.

By mutual agreement with the client, advice on further treatment or a meaningful return home is worked out. During his stay the client is motivated to address his problems in a different way, but the final choice and decision rest with him/her. We offer him/her the means to make his/her own choice.

A hierarchically structured therapeutic community

The target group of the therapeutic community (TC) De Sleutel are the drug addicts who have come stuck in a development phase but who can still grow. The community is open to men as well as to women.

The objective of the residential programme of the TRTC is to start the development processes of the addict again and to continue these processes. The ultimate aim is to achieve the drug-free reintegration of the client, i.e. ex-residents should be able to live a happy life again without the use of drugs even in difficult times. In order to optimise the chances of reintegration, we apply a reintegration programme with permanent guidance at our Transit House in Ghent.

Admission to the TC is generally preceded by a stay in the CDC where the client follows an introduction programme. An inventory of the real state of affairs of the client with respect to his social, family, relational, professional, financial and judicial situation is made. Finally, the treatment plan of the first two months is drawn up. Meanwhile the client is given sufficient information about a TC and about the consequences of his/her admission. Exceptionally if physical rehabilitation is not needed, the client can be admitted directly to the TC.

Possible counter-indications of a TC admission are:

- psychiatric syndromes, e.g. a psychosis characterised by disorders in the conception of reality though not caused by drug use,
- uncontrollable aggressive acting out,
- a mental disability.

The TC is a residential programme that aims to inform the addict about his stalled development processes and to change them into healthy processes. This is achieved by the input of psychotherapy (emotion), sociotherapy (behaviour, attitudes) and system approach. Furthermore, there is medical treatment and judicial guidance.

Generally we can say that the treatment consists of addressing the problems from all sides with the emphasis on the client's own responsibility. After the introductory period in the CDC, his stay at the TC commences; it can be divided into three main phases.

- Phase 1 (0-3 months) focuses in particular on the integration of the client into the group.
- Phase 2 (3-9 months) aims at integration of the new behaviour.
- In Phase 3 (9-12 or 15 months) trying out and affirming the acquired attitudes dominate. Making new relations is then also the main point of attention.

The TC is hierarchically structured; each resident has his/her responsibility in the structure which stretches from employee over those responsible for others to the co-ordinator of the TC. The day programme starts at 6.45am and ends at 23.30pm.

Two things are excluded from the TC:
1. bringing in or using drugs, alcohol or medication,
2. using physical force or threatening to do so.

Of course, there are more house rules; if these are not adhered to the consequences are that a therapeutic feedback is given.

After about a year the resident moves to the Transit House (re-entry), which focuses on the direct integration of the resident into society and on diverse aspects of society.

The transit programme also consists of three phases:

- Phase 1, the resident does in-service training so that he is confronted with the reality of work and takes treatment in one of the sections of De Sleutel.
- Phase 2, the resident seeks employment or training outside the structure of De Sleutel.
- Phase 3, the resident lives on his own; he can still rely on individual guidance and continues to take part in the intermission discussion.

The Psychotherapeutic Community

The target group of the psychotherapeutic community (PTC) "Ovaal" are the drug users with severe personality disorders which may have judiciary antecedents; therefore, special attention is paid to people interned. The age limits are between 18 and 40. For the time being, only men are admitted. The ultimate objective is drug-clean re-socialisation although we may sometimes consider ourselves successful if social stabilisation is achieved.

Some clients turn up sporadically at the ambulant drug-care service, they are not suited to hierarchical communities and possess insufficient verbal capacities to find help through insight (of the past and future). That is the specific target group of PTC "Ovaal".

The intake procedure: every referring instance can contact the PTC. Thus, a potential resident must not contact us himself. If possible, the candidate resident is invited to an intake consultation at the PTC "Ovaal". If external circumstances (imprisonment, collocation, etc.) prevent this contact, an appointment with the candidate is made at his place.

With regard to motivation, our starting-point is that formulating external motivation reasons are sufficient. The fostering of internal motivation in order to achieve a process of change is a point on the agenda which is focused on in the initial period of the possible admission.

The objective of the intake consultation is to verify, together with the client, which healthy elements his personality possesses and if he/she is willing to subscribe to the house rules.

The intake consultation is finalised by the intake-officer of the PTC. After discussion with the section-head a decision is quickly taken. In case of admission, it is done as soon as possible; if the outcome is negative, advice is given if at all possible, or the client is referred to one of the other sections of De Sleutel.

Turning away a candidate resident may be done for several reasons, be it that his problem profile does not agree with the PTC or that there are counter-indications like:

- physical disease which requires admission to a general hospital,
- acute physical symptoms,
- acute alcohol and/or drug intoxication,
- mental disability.

As general format of guidance we opted for the psychotherapeutic community module. This methodology is based on some important principles:

- taking responsibility according to capacity,
- respect for one another,
- speaking your mind in a healthy, open way,
- making choices,

- learning to make choices,
- learning to enjoy freedom.

Within the PTC there is a basic striving for a cosy family atmosphere in order to give the residents a sense of security.

We offer a structured day programme that has to be maintained - quite a challenge for a client, given his chaotic past. Much attention is paid to ADL training and to (re)integration by means of employment and retraining. Given the functional drug use of this group of addicts, psychotherapy is available in order to cope with their underlying psychic personality problems; the therapy takes the form of group sessions and individual therapeutic moments.

Appendix Number Four

Attendees

Adams, John, Training Centre Co-Ordinator, URRÚS
Bailey, Inez, National Adult Literacy Agency, Dublin
Barnett, Theresa, Community Addiction Counsellor, Eastern Health Board, Co. Kildare
Barry, Garda Charles J., Neighbourhood Policing Unit, Anglesea Street Garda Station, Cork
Blackmore, Sarah, Student Social Worker, Tallaght Mental Health Centre
Blake, Bill, Development Officer, Training, Comhairle Le Leas Oige
Bracken, Brigid, Community Addiction Response Programme, Tallaght
Brady, Cyprian, Dublin Central Constituency, Fianna Fail Party
Brady, Veronica, Community Addiction Counsellor, Eastern Health Board, Tallaght
Burke, Brid, Co-Ordinator Family Support Services, Community Response, Dublin
Butler, Elaine, Drug Awareness Programme, Crosscare, Dublin
Byrne, Charlie, Clondalkin Addiction Support Programme,
Cahill, John, Blanchardstown Youth Service, Foroige, Dublin
Casey, Claire,, Community Action Programme, Ballymun
Clarke, Brid, Director Of Child Care & Family Support Services, Eastern Health Board
Clerkin, John,, Children's Protection Society
Cooke, Sean, Ballymun Partnershi
Corry, Rosemary, Probation & Welfare Officer, Sarsfield House Hostel, Dublin
Darcy, Eddie, Care Worker, Lionsvilla Hostel, Dublin
Dargan, Dr. Deirdre, Community Care Area 2, Eastern Health Board, Dublin
De Loose, Annemie, Head Of Department Of The Daycentre, De Sleutel, Belgium
Docherty, Anne, Kilcross Residents Association, Sandyford, Dublin
Doherty, Vincenti, Eastern Health Board, Dublin
Dolan, Pat, Co-Ordinator, Adolescent & Family Support Services, Western Health Board
Dooley, Deirdre, Registered General Nurse, Cuan Dara Detoxification Unit,Dublin
Dowling, Jacinta, Community Addiction Counsellor, Eastern Health Board, Dublin
Duffy, Joan, Finglas South Community , Development Programme
Edwards, Wenda, Management Committee, Ballymun Youth Action Project
English, Geraldine
Fitzgerald, Michael, Child Psychiatrist, Eastern Health Board, Dublin
Fitzgerald, Paddy, Principal, Holy Spirit Boys School, Ballymun
Fogarty, Catherine, Community Addiction Counsellor, Eastern Health Board, Co. Kildare
Fogarty, Sheila, Dublin Aids Alliance
Foley, Anthony, Probation & Welfare Officer, Probation And Welfare Service, Dublin
Foley, Brian , Outreach Counsellor, Ballymun Youth Action Project
Forde, Dr. Deirdre, Senior Area Medical Officer, Eastern Health Board, Co. Kildare
Foy, Paul, Crew Network, Adult Education, St. Patricks College, Maynooth
Gallagher, Ellen, Talbot Centre & Inter Agency, Drugs Project, Dublin
Gilligan, Gabrielle, Administrative Assistant, Urrus
Gilligan, Robbie, Head Of Social Studies, Trinity College
Gilmer, Dr. Barbara, Community Care Area 2, Eastern Health Board, Dublin
Greaves, Hugh, Community Development Worker, Ballymun Youth Action Project
Hamill, Dr. Rosemary, Community Care Area 2, Eastern Health Board, Dublin
Hanlon, Evelyn, Dublin Corporation
Hickey, Dr. Lorraine, Director, Community Care Area 9, Eastern Health Board, Co. Kildare
Holland, Cathal, Trainee Addiction Counsellor, Ballymun Youth Action Project
Houlahan, Jack, Director Of Training, Northlands Institute, Derry
Hughes, Ann Marie, Administrator, Ballymun Youth Action Project
Kane, Mark, Focus Point, 14a Eustace Street
Kavanagh, Dermot, Co-Ordinator, Franciscan Social Justice Initiative
Kavanagh, Mairead, Clients/Programmes Co-Ordinator, Ballymun Youth Action Project
Keating, Joan, Chair, Young Fianna Fail
Keating, Rory,, P.A.C.E., Priorswood Hostel
Keen, Jane, Senior Probation & Welfare Officer, St. Patrick's Institution, Dublin
Kildea, Garda Jack, Community Garda, Ballymun Garda Station

Kilgallon, Audrey. Addiction Counsellor, National Drug Treament Centre
King, Angela, Youth & Community Worker, Geraldstown House, Ballymun
Lacey, Jim, Rutland Centre Ltd., Dublin
Lacey, Michael, Social Worker, Department Of Defence
Leahy, Noreen, Heahh Promotion Officer, Southern Health Board, Cork
Leonard, Tom, Ballymun Partnership
Lewis, Peter. Focus Ireland Ltd.
Long, Marian, Home/School Liaison Co-Ordinator, Holy Spirit Schools, Ballymun
Lucy, Eileen. Senior Comprehensive School, Ballymun
Lynch, Sr. Catherine, Infant Jesus Sisters, Ballymun
Mc Cormack. Martin, Community Care Area 8, Eastern Health Board, Dublin
Mc Namara, Mary, Cuan Dara Detoxification Unit, Eastern Health Board, Dublin
Mccann, Mary Ellen, Co-Ordinator, Ballymun Youth Action Project
Mcdonagh, Fr. Kevin, Parish Priest, St. Joseph's Parish, Ballymun
Mcgrory, Siobhan, Health Education Officer, National Youth Council Of Ireland
Meehan, Laura, Staff Welfare, Dublin Corporation
Monaghan, Louise, Lucan/Nth. Kildare Youth Service, Catholic Youth Council
Morgan, Sr. Gabrielle,, Holy Spirit School, Ballymun
Morris, Chris, Assistant Principal, Probation And Welfare Service
Morrow, Ruby, Psychologist, Department Of Education, Dublin
Mullen, Phyl, Management Committee Member, Ballymun Youth Action Project
Mullen, Regina, Community Care Area 8, Eastern Health. Board, Dublin
Murphy, Chris, Drugs Awareness Programme, Crosscare, Catholic Social Services Conference
Murphy, Mary, Care Worker, Sarsfield House Hostel, Dublin
Murphy, Dr. Evan, Community Care Area 8, Eastern Health Board, Dublin
Murray, Maria, Trainee Addiction Counsellor, Ballymun Youth Action Project
O'Cuiv, Liam, Holy Spirit Parish, Ballymun
O'Brien, Liam, Co-Ordinator, Community Addiction Response Programme
O'Connor, Breda,, Management Committee Member, Ballymun Youth Action Project
O'Flynn, Mary, Principal, Holy Spirit Girls School, Ballymun
O'Gorman, Aileen, Health Research Board
O'Hara, Catherine, Outreach Co-Ordinator, Ballymun Youth Action Project
O'Quigley, Rita, Community Addiction Counsellor, Eastern Health Board, Co. Kildare
O'Shea, James, Community Addiction Counsellor, Eastern Health Board, Dublin
Parker, Mona. Addiction Counsellor, Ballymun Youth Action Project
Peavoy, Celine, Management Committee Member, Ballymun Youth Action Project
Prendergast. Sr. Catherine, Sign Partnership, St. Vincents Trust, Dublin
Quinn. Jean, Focus Ireland Ltd.
Rackard, Marion, Senior Counsellor, Community Alcohol Services, Tallaght
Reaper-Reynolds, Sheilagh, Talbot Centre & Inter Agency , Drugs Project, Dublin
Redmond, Sean, P.A.C.E., Priorswood Hostel
Rodgers, Aoife, Dublin Weekend Radio
Roe, Bernie, Drug Awareness Programme, Crosscare, Dublin
Rooney, Bernie, Community Mothers Programme, Geraldstown House, Ballymun
Rossiter, Antoinette, Clinical Psychologist, Mater Dei Counselling Centre
Roynane, Tom , W.R.C., Social And Economic, Consultants Ltd.
Shaughnessy, Frank, Advice Worker, Threshold, Dublin
Steen Jensen, Peter, General Manager, Odense Kommune, Denmark
Treacy, David, Director, Comhairle Le Leas Oige, Dublin
Tyler, Tina, Clerical Assistant, Ballymun Youth Action Project
Wade, Jane, Community Addiction Response Programme, Tallaght
Wall, Kathryn, Drug Awareness Programme, Crosscare, Dublin
Walsh, Dr. Mary, Community Care Area 5, Eastern Health Board, Dublin
Waterstone, Aidan, Eastern Health Board, Dublin
Weldon. Kathleen, Le Cheile 2

“It is essential that children do not fall from the net of their family, school and community.”

– Pat Dolan, Conference Speaker and Acting Co-ordinator of Adolescent and Family Services, Western Health Board, Galway

URRÚS

A Ballymun Youth Action Project Initiative

IRELAND'S COMMUNITY ADDICTION STUDIES TRAINING CENTRE

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On the 6th of November 1996, URRÚS - Ireland's Community Addiction Studies Training Centre (A Ballymun Youth Project Initiative) hosted a day long conference entitled:

"Joint Systems Approaches for the Prevention of Drug Misuse"

The conference explored ways to improve services for the care of young people at risk in relation to drug misuse.

The day featured a number of nationally and internationally recognised experts including:

Ms. Liz McManus,
Minister of State at the Department of the Environment, with special responsibility for Housing and Urban Renewal.

Mr. Robbie Gilligan,
Head of Social Studies, Trinity College, Dublin.

Mr. Pat Dolan,
Co-ordinator of Adolescent and Family Services, Western Health Board, Galway.

Ms. Annemie De Loose,
Head of Department of the Daycentre of Malines, Belgium.

Mr. Jack Houlahan,
Training Co-ordinator, Northlands Institute, Derry, Northern Ireland.

Mr. Peter Steen Jensen,
General Manager, Odense Kommune, Denmark.

It is hoped that this conference has served as a catalyst for change in Ireland and that the needs of young people will be central to all future policy decisions.

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