TALLAGHT REHABILITATION PROJECT (TRP):

A REVIEW REPORT

BARRY CULLEN
DR. GEMMA COX

ADDICTION RESEARCH CENTRE,
TRINITY COLLEGE DUBLIN

CONTENTS

INTRODUCTION

The Tallaght Rehabilitation Project (TRP), a community-based programme for recovering drug users was initiated in 1997, by a decision of the Tallaght Local Drug Task Force and with the support of area-based health board drug workers. The project is an independent legal entity and was set up to offer a therapeutic programme to assist drug users in dealing with their addiction and to become and remain drug free. In 1998 the project was granted preliminary set-up finance and recruited a manager. In 1999 a temporary premises was secured at nominal rent at St. Thomas's Church, Jobstown and an agreement was made with FAS to operate
a Community Employment (CE) scheme as a special category vocational-rehabilitation project for persons who were recovering drug users. First entrants onto the programme commenced in December 1999 and twenty months later, during the summer 2000, the project decided to initiate its own review. A review contract was awarded to the Addiction Research Centre and work on the project commenced in July 2001. Fieldwork continued over a period of seven months. A preliminary verbal feedback report on issues arising in the project was conducted in December 2001. A draft evaluation report was submitted during April and this Final report was submitted and agreed in September 2002.

The main aims of this review (and report) are:
- to examine the impact and effectiveness of the TRP with particular attention to how it meets its own stated aims and objectives;
- to analyse the perspectives of TRP participants with respect to their engagement and satisfaction with the programme;
- to examine TRP's wider policy and practice contexts with particular attention to assessing its integration with local developments.

In planning this evaluation it was initially intended that it take place time-limited a concentrated, time-limited manner over a period of two months. However, this approach was later adjusted so that the process of collecting information was extended over a much longer period thus providing the research team with more flexibility to study the project in a more intensive manner. The main data was collected using qualitative method: a mixture of in-depth interviews, group discussions and observations. Each member of TRP staff was interviewed and most was interviewed twice. At the outset of the review there were ten current participants and each of these was also interviewed with a 3-4 month gap between each interview. In addition a number of management committee members was also interviewed. A flexible topic guide was used for these interviews, rather than a rigid set of questions. This data was complemented by a number of observations involving both formal and informal group meetings in the project. There was also a quantitative component through an assessment of client records. Given the importance of the project's community base both as a location for rehabilitation / reintegration and as a resource for referrals a number of discussions were also held with personnel from external agencies and bodies.

A number of caveats need to be recognised when assessing programme effectiveness in a project such as this. There is potentially a diverse range of perspectives on what constitutes appropriate indicators of programme effectiveness. For example, does programme effectiveness mean that persons have become abstinent from drugs, and if so which drugs? Does it mean that persons have maintained stable levels of drug intake or that they no longer use illegal drugs? Or indeed, does it mean that persons have made important changes in their social and personal lives, quite apart from drugs? The list of possible changes through a programme such as this is inestimable and I the absence of a control group, it is difficult to attribute any individual change and improvement directly to the programme. Moreover, the fact that the effects of the programme may be indirect, or may not be felt for many years makes it difficult to draw direct connections between programme effectiveness and individual outcomes. Inevitably, many questions remain unanswered, and it will never be possible to arrive at a definitive and non-contentious assessment of the extent to which any rehabilitation programme is 'effective' in its work. At this stage however, what is particularly important is that the experience of this programme to date is properly documented and analysed within a framework that allows for a review of progress, further programme development and planning, as well as facilitating future research and enquiry.

This report is presented in six sections as follows. Section 1 examines the background to TRP's establishment, with an overview of the main developments in drug treatment research and policy. Section 2 assesses the emergence and development of TRP with particular attention to the local contexts and issues affecting its formation. Section 3 profiles TRP's participants in the context of the project's referral and assessment procedures.. Section 4 reviews the operation of TRP with particular attention to its aims and objectives, programme outline, features and procedures. Section 5, reviews the perspectives of project participants with respect to their engagement with, and assessment of, the programme. Finally, Section 6 draws together a summary of the main themes in the report and outlines key recommendations for further development[1].

---

[1] Please note that this Final Draft of the report has yet to be sent to a copy editor.

SECTION 1:
COMMUNITY DRUG TREATMENT AND REHABILITATION – THE WIDER POLICY CONTEXT

The community based rehabilitation project that is the subject of this report was set up in the context of a substantial investment into drug treatment and rehabilitation that commenced in the mid 1990s, a policy investment perceived by many as belated. For over two decades drug misuse in Ireland, particularly the illicit use of heroin and other opiates in Dublin, featured as a major health and social problem. Opiate user estimates, which don't have a great deal of reliability, currently vary between 6,500-13,000 in Dublin[2]. Over the last two decades the drug problem has generated a great deal of public and media interest, reflecting the problem's criminality and also reflecting other very serious consequences, which have manifested in quite profound ways. Since they first escalated in the late 1970s, opiate problems were concentrated in a small number of public housing estates in the Dublin area[3], estates indeed that were particularly badly affected by the processes of recession, de-industrialisation and public expenditure cutback[4]. The drug problem emerged and developed alongside long-term unemployment and its particularly disruptive impact on family and local social life[5].

The effects of drug problems in local communities such as public estates in West Tallaght where TRP is located are extensive and the literature on these may be summarised with respect to individuals, families and communities. First, there are the effects on individual problem drug-users and these include the risk of addiction, the risk of infection by human immuno-deficiency virus (HIV) and hepatitis C virus (HCV), of overdosing, of serious illness and of premature death[6]. Long-term problem drug users also face the prospect of becoming isolated from families, marginalised by society and rejected by their communities (evicted), and homeless[7]. They risk moreover, an involvement in crime and of getting caught and being imprisoned[8]. The longer they are embedded in a drug-using, criminal lifestyle or drug-using prison culture, the more difficult for them to rehabilitate and reintegrate into normal society[9].

---

[2]   Comiskey, C.(1998) *Estimating the Prevalence of Opiate Use in Dublin*, Unpublished report, Department of Health and Children.)

[3]   Moran, R., O'Brien, M., Duff, P. (1997) *Treated Drug Misuse in Ireland, National Report – 1996*, Dublin: Health Research Board.

[4]   Donnison, D., Bell, D., Benington, J., Blackwell, J., Elphick, C., McArthur, A., McKeown, K., O'Shea, E. (1991) *Urban Poverty, the Economy and Public Policy,* Dublin: Combat Poverty Agency.

[5]   For a wider consideration of the effect of inter-generational employment experiences on family and community drug problems, see Currie, E. (1993) *Reckoning: Drugs, the Cities, and the American Future,* New York: Hill and Wang.and Advisory Council on the Misuse of Drugs (ACMD) (1998) *Drug Misuse and the Environment*, London: The Stationery Office.

[6]   O'Brien, M., Dillon, L. (2001) "Health Issues and Consequences of Drug Misuses" in Moran, R., O'Brien, M., Dillon, L., Farrell, E., Mayock, P.*Overview of Drug Issues in Ireland, 2000*, Dublin: Health Research Board).

[7]   Dorman, P., Jones, L. (1999) *Rehabilitation Research Project: Towards a blueprint for rehabilitation for opiate addicts in the Eastern Health Board area,* Dublin: Eastern Health Board.

[8]   O'Mahoney, P. (1997) *Mountjoy Prisoners: A Criminological and Sociological Profile*, Dublin: Government Publications.

[9]   Dillon, L. (2001) *Drug Use Among Prisoners: An Exploratory Study,* Dublin: Health Research Board

Second, there is the effect on families. As family processes become influenced by addictive behaviours, relationships can break down[10] and the needs of children and other vulnerable members get neglected[11]. Moreover, family members experience the pain, trauma and grief of drug-related illness and death, of providing long-term care for other members' children who are being raised amidst drug-use, police raids and child protection systems[12], and of continuing to care for adult drug-using members following years of addiction and illness[13].

Third, the effects of dense and visible drug misuse becomes a problem for entire neighbourhoods, including those members who are not directly involved, reinforcing a picture of drug misuse as a norm with consequences that constantly impinge on daily social and economic life[14].The more problem drug use in any particular geographical area the more drug-related crime[15]. Persons living in a community with a drug problem are at higher risk of being a victim of crime[16]. Alongside such direct effects, there is a fear of crime, of being a victim of crime and also a fear of disorder[17]. Alongside these effects, it is evident, as already mentioned, that many estates in which drug problems escalated have lacked community infrastructure, amenities and social services. This overwhelming experience of poverty and disadvantage reinforces a sense of residents being unable to escape the forces that exclude them from participating in society[18]. Furthermore, statutory authorities are perceived as having failed to develop coherent responses to multiple problems in such neighbourhoods[19], thus leaving it to community groups, often with very little resources, to pioneer new approaches and interventions[20].

Throughout the 1980s, alongside crime control measures, the main social and health policy response to community drug problems reflected a disease model of addiction, an approach that emphasises individual responsibility as contingent to successful treatment. This model

[10] McKeown, K., Fitzgerald, G. (1999) *Treating Drug Addiction: An Evaluation of Addiction Response Crumlin,* Dublin: Addiction Response Crumlin.

[11] Hogan, D., Higgins, L. (2001) *When Parents Use Drugs: Key findings from a study of children in the care of drug-using parents,* Dublin: Children's Research Centre, Trinity College.

[12] Woods, M. (2000) "Women, drug use and parenting in Dublin: The views of professional workers in the drug treatment and social work fields", in A. Springer, A. Uhl (Eds.) *Illicit Drugs: Patterns of Use – Patterns of Response: Proceedings on the 10th Annual ESSD Conference on Drug use and Drug Policy in Europe,* Innsbruck: Studien/Verlag.

[13] Murphy-Lawless, J. (2001) *Motherhood and Drugs: Women, Family Life and the Impact of Heroin in North Inner City Dublin* (limited circulation).

[14] MacCarthaigh, T. (2001) "The Social Environment of Young People's Choices" in P. Mayock (ed.) *Drugs and Drug Problems: Reporting on the Perspectives of Young People*, proceedings of a half-day conference held in Robert Smith Lecture Theatre, Trinity Medical Centre, St. James's Hospital, Dublin 8 September 20th, 2000, Dublin: Children's Research Centre.

[15] Chaiken, J., Chaiken, M. (1990) "Drugs and predatory crime" in M. Tonry and J. Wilson (eds.), *Drugs and Crime: A Review of Research*, Chicago: University of Chicago Press.
Johnson, B, Goldstein, P., Preble, E., Schmeidler, J., Lipton, D., Spunt, B., Miller, T. (1985) *Taking Care of Business: The economics of crime by heroin users*, Lexington, MA: Lexington Books.

[16] Keogh, E. (1997) *Illicit Drug Use and related Criminal Activity in the Dublin Metropolitan Area,* Dublin: An Garda Siochana.

[17] Fahey, T. (ed) (1999) *Social Housing in Ireland: a Study of Success, Failure and Lessons Learned,* Dublin: Oak Tree Press.

[18] Donnison, D., Bell, D., Benington, J., Blackwell, J., Elphick, C., McArthur, A., McKeown, K., O'Shea, E. (1991) *Urban Poverty, the Economy and Public Policy,* Dublin: Combat Poverty Agency.

[19] Kelleher, P. Whelan, M. (1990) *Dublin Communities in Action: A Study of Six Community Projects,* Dublin: Community Action Network / Combat Poverty Agency.

[20] Cullen, B. (1994) *A Programme in the Making: A Review of the Community Development Programme*, Dublin: Combat Poverty Agency.

has greatly influenced US drug and alcohol treatment policies[21], but has also been subjected to quite a lot of philosophical criticism[22]. In the UK and other European countries there is more a tendency towards viewing drug and alcohol addiction from problem-focused rather than medical or disease perspectives[23]. For most of the last 25 years the main drug treatment services in Ireland required prospective clients / patients to adopt a prior commitment to abstinence as a condition of treatment and in general treatment options were few and had limited objectives: detoxification, drug-free counselling and drug-free residential rehabilitation[24]. One of the main weaknesses of this approach is that its formulation of successful outcome rests on sustaining persons in a constant state of being drug-free, albeit on a day by day basis. The model has little, if any, room for other - and perhaps more common - formulations, for example: being able to continue to take drugs, including prescribed substitutes, without experiencing drug-related problems[25].

With official policy during the 1980s securely tied to abstinence-based treatment, many localised, community responses to drug problems, bar a few exceptions, drew from this disease model and viewed short-term detoxification leading to intensive drug-free rehabilitation as the key to effective treatment. Despite the principled intentions of many of the model's advocates– intentions that in the main sought to get a good deal in terms of services for drug users - the overall dominance of this approach achieved little and indeed stymied public-health oriented initiatives. This was especially the case in worst affected communities, where the everyday picture of large numbers of young heroin addicts constantly engaged in local drug markets and operating outside the orbit of treatment services, continued to be sustained. Inevitably an intolerance of drug users developed, alongside a heightening of community fears leading to community protests and highly public acts of anti-drug vigilantism. Meanwhile, the already deteriorating social conditions of communities where drug problems were most pervasive was further intensified, contributing to a deepening of poverty and compounded by a greater local reliance on underground drug economies[26].

---

[21]   Miller, N. (1991) "Drug and alcohol addiction as a disease", *Alcohol Treatment Quarterly*, 8 (4), 43-45.
[22]   Fingarette, H. (1988) *Heavy Drinking – the Myth of Alcoholism as a Disease,* London: University of California Press.
[23]   For example, detailed evidence and arguments against the notion of alcoholism as a disease is presented in the book *Problem Drinking*, in which the authors argue that alcohol problems are best understood as examples of socially learned behaviour (Heather, N., Robertson, I. [1997] *Problem Drinking*, Oxford: Oxford University Press). The incorporation of the concept problem drug-taker into mainstream treatment and rehabilitation is signalled in an official 1982 UK report (Advisory Council on the Misuse of Drugs [1982] *Treatment and Rehabilitation*, London: HMSO). Contrasting European and US perspectives in relation to the relative influence of disease models on contemporary thinking with respect to addiction treatment are evident in the review: Buhringer, G., Gossop, M., Turk, D., Wanigaratne, S., Kaplan, C. (2001) "European perspectives on relapse and relapse prevention" in F. Timms, C. Leukefeld, J. Platt (eds.) *Relapse and Recovery in Addictions,* London: Yale University Press..
[24]   Butler, S. (1991) "Drug problems and drug policies in Ireland: A quarter of a century reviewed', *Administration*, 39(3), 281-292.
[25]   For example an alternative to abstinence definition of recovery is: "..the stabilisation of abstinence, or the regular consumption of a substance without the negative consequences previously associated with drug use" (Babor, T., Cooney, N., Lauerman, R. [1986] "The drug dependence syndrome as an organising principle in the explanation and prediction of relapse" in F. Tims, C. Leukefeld, *Relapse and Recovery in Drug Abuse*, NIDA Research Monograph 72, Mashington DC: US Government Printing Office.
[26]   For a discussion of these processes in the Irish experience see Cullen, B. (forthcoming) *Community and Drugs: Key issues for neighbourhood responses to drug problems in Dublin*, Dublin: Addiction Research Centre, Trinity College.

The worsening predicament of such communities during the 1990s eventually generated a discussion around the need for a wider variety of treatment and rehabilitation options, alongside the need for more focused, economic and social responses[27]. This discussion took place within the context of community development and urban regeneration[28], which reflected and contributed to the development of community prevention and education programmes[29] and low profile drug awareness groups[30] as well as a number of innovative community services[31]. Against a background of some community opposition to the local siting of statutory drug treatment facilities, community organisations began to occupy a particularly important, if at times dubious, place in demanding new approaches and policies[32]. A central tenet of their demands was that problems that emerge within particular social contexts are often best resolved within the same contexts, and a related principle was that local drug treatment facilities should be for local people alone. In this regard the treatment and rehabilitation of drug users is seen as something that could take place primarily within their own communities and through the utility of facilities that are decidedly community in their structure, management and operation[33].

Arising from these developments, community organisations that were involved in anti-drug community actions during the 1990s subsequently became directly involved in providing local treatment services[34]. Although some organisations were previously dedicated to the disease or abstinence model, their new involvement in treatment extended to the provision of drug substitution programmes (methadone maintenance) in a radical policy innovation described as unique in Europe[35]. This was a remarkable transformation and demonstrates the success of pragmatism in drug treatment. It also brings new challenges, particularly for those drug users, family members, community members and drug service practitioners, *who believe that an effective treatment response must transcend the provision of drug-substitution programmes alone*[36]. Out of this belief a range of psychosocial supports and services for drug users, including the Tallaght Rehabilitation Project (TRP), has developed.

While the development of new services, such as the TRP, arose from the demands of local community agencies they also reflected changes in the way drug problems were represented in contemporary public health discourse. The narrow focus on abstinence presupposes that

---

[27]   Ana Liffey Drug Project. (1990): *Drug Treatment Policies - A discussion document*. Dublin: Author.
[28]   Lambe, S. (1997) "The experience of the Inner City Renewal Group" in *Drugs Poverty and Community Development: A Report of the Conference for Community Development Programme Projects on Community Responses to Drugs Issues, held in February, 1997,* Dublin: Combat Poverty Agency.
[29]   Rourke, S. (1999) *Summary Evaluation of Community Drug Workers Training Course*, Dublin: Community Response.
[30]   Butler, E. (2000) *Community Development as a Means of Drug Prevention*, Unpublishd thesis submitted in part fulfilment of the Higher Diploma in Adult and Community Education, National University of Ireland, Maynooth.
[31]   McKeown, K., Fitzgerald, G. (1999) *Treating Drug Addiction: An Evaluation of Addiction Response Crumlin,* Dublin: Addiction Response Crumlin.
[32]   Bowden M. (1997) *Community Addiction Response Programme CARP – Killinarden: Review and Interim Evaluation,* Dublin: CARP – Killinarden.
[33]   Bowden, M. (1996) *Rialto Community Drug team – Policy Discussion Paper*, Dublin: Rialto Community Drug Team.
[34]   O'Brien, L. (2000) *A Case Study of Heroin Users in Methadone Treatment in their own Community,* Thesis submitted for MSc in Drugs and Alcohol Policy, University of Dublin, Trinity College.
[35]   Farrell, M., Gerada, C., Marsden, J. (2000) *External Review of Drug Services for the Eastern Health Board,* London: National Addiction Centre.
[36]   McKeown, K. (1998) *Feasibility Study on a Drug Rehabilitation Service in Canal Communities*, Dublin: Canal Communities.

this condition is relatively easily achieved and sustained. However, research findings illustrate that many drug users return to drug using even after long periods of abstinence[37]. In a familiar drug-supplying environment in particular, the ability of those, who have been drug dependent, to extinguish their desire for drugs following a single episode of treatment is exceptionally difficult and complex[38]. Thus, the assessment of treatment outcomes needs to be concerned less with quantifying the numbers who are classified drug-free after specific episodes of treatment and more with the extent to which drug users' problematic behaviours, measured periodically, continue to make positive changer[39]. Longitudinal drug treatment research highlights that there is no single type of problem drug user and that multiple treatment strategies – over time - are required in order to address the diverse needs of different drug-using populations[40]. While the goal of abstinence has application within specific programmes and for particular drug user types, its persistence – as the only goal – can serve to discourage drug users into treatment[41]. Following the escalation of HIV and hepatitis infections among injecting drug users during the mid to late 1980s, it became imperative that new, more wide-ranging goals were needed in order to attract and keep drug users in treatment[42]. This change represented a shift in Irish policy away from a reliance on the abstinence or the disease approach towards supporting a more flexible model of community-based treatments[43],and potentially with the involvement of general practitioners who hitherto had played no significant role in the provision of public treatment services to drug users[44].

The new model is based on public health principles and its analysis of the dynamic interaction of agent-host-environment, corresponding to the drug-set-setting framework that has been outlined for drug problems[45]. The agent (drug) is a specific factor whose absence or presence contributes directly to ill-health. The host (set) is the individual with a particular susceptibility to ill health as a result of agent's absence or presence. The environment (setting) is the physical and social factors, external to the host, that affect susceptibility. These latter factors include family, housing, school, community, availability of employment and services, and the absence or presence of social problems: poverty, unemployment and economic decline. In recognising the interaction between these elements, the new model advocates the necessity for dealing with all three. Key principles underlying this response include the idea of multiple causation and the integration of varied interventions.

---

[37]   Gerstein, D., Harwood, H. (1990) *Treating Drug problems (Vol. 1): A study of the evolution, effectiveness, and financing of public and private drug treatment systems,* Washington, DC: National Academy Press.

[38]   Anglin, D., Hser, Y. (1990) "Treatment of drug abuse", in M. Tonry, J. Wilson (eds.), Drugs and Crime: A Review of Research, Chicago: University of Chicago Press.

[39]   *Ibit.*

[40].   Anglin, D., Hser, Y., Grella, C., Longshore, D., Prendergast, M. (2001) "Drug treatment careers: conceptual overview and clinical research, and policy applications", in F. Tims, C. Leukefeld, J. Platt *Relapse and Recovery in Addictions,* London: Yale University Press.
        Platt, J. (1995) *Heroin Addiction: Theory Research, and Treatment (Volume 3, Treatment Advances and AIDS),* Malabar, FL: Krieger Publishing Company.

[41]   Gerstein & Harwood (1990)

[42]   Hubbard, R., Marsden, M., Cavanaugh, E., Rachal, J., Ginzburg, H. (1988) "Role of drug abuse treatment in the spread of AIDS", *Review of Infectious Disease,* 10(2):377-84.

[43]   Department of Health. (1991): *Government Strategy to Prevent Drugs Misuse.* Dublin: Author.

[44]   Irish College of General Practitioners (1990) *Policy Statement on Illicit Drug Use and the Problems of Drug Addiction,* Dublin: ICGP

[45]   Zinberg, N. (1984) *Drug, Set, and Setting : the basis for controlled intoxicant use,* London: Yale University Press.

In particular these include the use of drug substitution medications to help control or modify withdrawal, reduce craving and prevent relapse. Methadone maintenance for opiate users is the most common example of this form of treatment. It developed in the US during the early 1960s and its early proponents argued that persons addicted to opiates experience a metabolic disorder and that methadone – taken in sufficient amounts - normalised the dysfunction, thereby removing the craving and blocking the euphoric effects and providing the individuals concerned with the opportunity to avail of psychotherapeutic and social services in improving their social and psychological functioning[46]. Studies on methadone maintenance show that, *provided it is used with sufficiently high levels of dosage,* it has a positive impact on reducing crime, on reducing the transfer of HIV and on reducing mortality and morbidity associated with illicit drug use[47].

On the face of it such improvements, particularly in relation to crime, might be seen as having greater benefit for the wider community than for individual drug users. Many of the latter, it might be argued, continue a life of addiction with underlying social and psychological problems – poverty, unemployment, and fractured relationships with family and community – that potentially remain un-addressed, within the context of methadone programmes. It is quite evident that most heroin-users in Ireland come from poor backgrounds and have experienced problems in relation to social exclusion. It would be somewhat unrealistic to expect that methadone maintenance alone would remedy the problems that have gathered momentum over years, and perhaps even over generations. Methadone maintenance of course, does potentially provide the stability wherein these other issues can get addressed. But, basically, deeper explanations of drug problems are required in order that particular individual or community drug problems become transformed.

Although government policy officially provided support to the new model in 1991, it was slow to take effect, and it was not until the publication of the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs[48],* that a momentum towards this new approach escalated.Central to this report's recommendations was the setting-up of local drug task forces in the worst affected areas in the Greater Dublin Area. These local task forces have a partnership structure, bringing together state, community and voluntary organisations to devise and appraise plans for tackling drug problems in their areas. They link in with a National Drug Strategy Team, which itself includes a membership drawn from statutory, voluntary and community agencies. Since this new policy was formulated there has been a large expansion in the involvement of public health agencies in the provision of drug services. In particular, health boards have expanded their provision of methadone programmes, through community clinics and general practitioner services and with the involvement of community agencies[49]. Community agencies are also involved in rehabilitation programmes, drug education programmes in schools and youth clubs and other community-based prevention activities, which are provided through community centres,

---

[46]   Dole, V., Nyswander, M. (1965) "A medical treatment of diacetyl-morphine (heroin) addiction", *Journal of the American Medical Association*, 193:646-50.

[47]   Ward, J., Mattick, R., Hall, W. (1998) *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*, Amsterdam: Harwood.

[48]   *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1996), Dublin: Stationery Office.

[49]   Farrell, M., Gerada, C., Marsden, J. (2000) *External Review of Drug Services for the Eastern Health Board,* London: National Addiction Centre.

after-school clubs and youth outreach programmes[50]. In 2001 this new drug policy was consolidated through the publication of *Building on Experience*, which commits National Development Plan funding and other resources to tackling drug problems until 2008[51], although, fears, that in the midst of an economic downturn, the political commitment to this policy may not be fully sustained have been expressed by the spokespersons of a number of community and voluntary agencies and others[52].

Conclusion

It is clear from the above discussion that patterns of drug-taking and the focus and intentions of drug policies, vary across time and place. The opiate problem that emerged in Irish society over the last two decades was concentrated in poor urban neighbourhoods. The dominance of abstinence-only models stifled the emergence of public health measures and, it would seem, exacerbated the situation in these neighbourhoods In the face of current research and knowledge it is hard to contemplate the narrowness of policies that supported this abstinence-only approach. Yet, however belatedly, new policies have emerged and public health and harm reduction now features as key elements of drugs policy. There is also a greater role for community bodies. These perspectives on the treatment of drug problems would have been given bare consideration a generation ago. Future generations will, conceivably, raise serious questions about the wisdom and efficacy of current policy, stressing as it does the importance of drug-substitution as a measure for reducing heroin-use, reducing drug-related crime, and reducing drug-related deaths, morbidity and infection. In much the same way as previous policy on drug treatment has been intensively re-examined, current policy on harm reduction also faces the prospect of future analysis and criticism. In the meantime, it is important to document the application of public policy, particularly in terms of charting the course of new initiatives and services that have emerged. The remaining sections of this report analyses the experiences of one community-based rehabilitation project that has clearly emerged and developed in the context of new policy.

---

[50]   Ruddle, H., Prizeman, G., Jaffro, G. (2000) *Evaluation of Local Drugs Task Force Projects : experiences & perceptions of planning & implementation,* Dublin: National College of Ireland, Policy Research Centre.

[51]   Department of Tourism, Sport and Recreation (2001) *Building on Experience – National Drugs Strategy, 2001-2008,* Dublin: Stationery Office.

[52]   A number of news paper articles published during the summer of 2002 express these sentiments, including one (Irish Times, 7/9/02, p.6) which includes quotes on this topic from an inner city local drugs task force coordinator, a director of a voluntary drug treatment agency, and a political representative for Tallaght area,

SECTION 2:
BACKGROUND AND EMERGENCE OF TRP

TRP is located in a housing estate, Jobstown, in West Tallaght, which is situated in Dublin county area, about 25 kms from Dublin city centre. Tallaght is a new town, one of three satellite towns around Dublin that were planned and built in the midst of Dublin's 1960's economic and population expansion. In 1967 the population of Tallaght was 2,000; within twenty years it had grown to over 80,000. For its first two decades Tallaght lacked any semblance of physical and services infrastructure that would be expected in a comparable town. Indeed, its continues to lack local autonomous administrative units, although in the last decade the situation improved dramatically with the local siting of a new hospital, institute of technology and the headquarters of Dublin South County Council. The area known as West Tallaght consists of housing estates, open spaces and a small number of industrial units (most of Tallaght's industrial and commercial activity is concentrated in its central and northern areas). West Tallaght housing estates are mainly public built and owned. Although the estates were built as a response to economic expansion, their early years were marked by economic recession and consequently the area was considered (and continues to be one of the most marginalised in the State. Over the years it has been badly affected by social problems: long-term unemployment, low educational achievement and high welfare dependency. Also, from the late 1980s the area had a high youth population and began to experience serious opiate problems.

The developments outlined in Section 1 set a broad context for the emergence of TRP. At a more local level the project grew out of community developments in West Tallaght as it began to respond to its own social problems. The wider community was, at the time, active and vocal in seeking to establish Tallaght as a distinct new town with a commercial, industrial and educational infrastructure as well as dealing with demands for a community and social service infrastructure. Alongside the development of a hospital, a regional third level college, shopping centre, a retail park, hotels and industrial units, there also developed various community organisations. These played a leading role in tackling local problems in getting community facilities built and in setting up community programmes dealing with issues such as women's education, early school-leaving, welfare rights, job training, lone parenthood, long-term unemployment and drug problems[53].

The Tallaght Local Drug Task Force (TLDTF) was one of 11 set up in Dublin (12 nationally) following the publication of the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996)*. As already outlined, the proposal to set up local task forces emerged from the demands of community organisations who submitted to the Ministerial Task Force: some, including community groups in Tallaght, were already providing drug treatment and other services in communities with but minimal support or sanction. The TLDTF brought together representatives from statutory, voluntary and

---

[53] Kelleher, P. Whelan, M. (1990) *Dublin Communities in Action: A Study of Six Community Projects,* Dublin: Community Action Network / Combat Poverty Agency.

community organisations concerned with drug issues in order to consolidate an effective, coordinated local response.

Alongside the task force the local health board was also a prime mover in bringing about new service developments. A reorganisation of community drug services in health boards had commenced in 1994 and is still ongoing. Since 1995, these services, along with HIV/AIDS and homeless services, have a separate health board management system and multi-disciplinary area-based teams. So, for instance, in Tallaght, there is an area field team of five nurses, three outreach workers and $2^{1}/_{2}$ counsellors, which is supported at a higher level by a consultant psychiatrist, a senior counsellor and a senior outreach worker, who also support other area field teams, as well as other health board wide services. The Tallaght field team works alongside sixteen local GPs who prescribe methadone both in surgeries and in designated community clinics, and pharmacists who dispense methadone at twelve private and three public service outlets (including a mobile clinic). This work is supported by a GP coordinator who covers the whole health board area, as does a pharmacy coordinator, who supports the work of public and private pharmacists. Altogether, there are now almost 600 persons in Tallaght on methadone programmes, which accounts for nearly 10% of those nationally who are on such programmes. Fifty per cent of persons in Tallaght on methadone programmes are prescribed directly by GPs in their own surgeries. About 250 attend community satellite clinics. These clinics were founded by community organisations and they provide an outreach base for weekly prescribing by GPs. One of these clinics also provides a daily dispensing service. With some variations, these clinics provide a range of social supports for attending drug users. These include advice on housing, income, education and employment and also include opportunities to participate in educational and vocational support programmes. The remaining 50 or so persons on methadone programmes attend one of: a health board satellite clinic, a mobile clinic or a separate drug treatment facility, Trinity Court, in Dublin city centre, about 12 miles away.

The area field team works in conjunction with all of the clinical and community services. Nursing services provide clinical support to methadone programmes. Outreach workers are engaged in sexual health and harm-reduction advice and information, pre- and post-HIV test counselling, contacting drug users and referring-on as appropriate and working closely alongside community clinics, community centres and various local youth and educational bodies. Addiction counsellors provide a range of psychosocial supports as required. In reflecting the overall thrust of the public health model, the counselling service works with individual drug users in a variety of different ways, depending on individual needs and abilities. Support towards both abstinence and harm reduction strategies is provided. While non-drug issues often arise, drug-use tends to be the key factor in counselling. In instances where serious co-existing problems are indicated, further referral is explored, through consultation with team's consultant psychiatrist. Other referrals would be to drug residential or day programmes or other relevant programmes with a specific capacity to deal with drug users.

It is possible to suggest that the emerging framework for local treatment and rehabilitation interventions in Tallaght include five *Service Elements* as outlined below. This is a non-formal outline of service elements and is used here in this report as a tool for understanding the local treatment context. The outline of service elements should not be confused with the

different levels in the Methadone Protocol, whereby doctors who participate at Level 1 or Level 2 differ in terms of both the number of patients they have and the procedures for taking on patients.

Element 1:   *Outreach*: seeking out and maintaining contact with drug users, providing information, harm reduction and access to basic medical facilities and low threshold methadone programmes, as appropriate.

Element 2:   *Drug-substitution:* methadone programmes (both detoxification and maintenance) provided solely on a clinical basis and in the absence of any external, formal psychosocial supports, but with the option of onward-referral, as appropriate.

Element 3:   *Basic psychosocial supports:* oriented towards helping drug users (former users and methadone programme participants) to stabilise, to deal with practical problems (housing, income, education, employment) and to avoid relapsing to serious patterns of drug-use, often provided alongside or as a part of drug substitution programmes.

Element 4:   *In-depth psychosocial supports:* counselling and psychotherapy to assist drug users deal with deeply rooted, personal and family problems affecting their drug-use.

Element 5:   *Local coordination and referral:* mechanisms for both formal and informal communication across different service elements and also for referral to more specialised services, both drug-related and non-drug-related, in both residential and other settings and including detoxification programmes and drug-free rehabilitation programmes.

This treatment framework reflects an eclectic approach to treatment practice, drawing in particular from the *stages of change* model[54]. This approach provides a basis for applying separate causal explanations for individual drug problems, justifying the use of multiple and even contrasting interventions by practitioners, depending on drug users' state of motivation, and willingness and capacity to change. The framework therefore needs to be able to include a range of responses corresponding to a wide variety of needs. In the context of Tallaght or other similar locally based treatment systems it would not be necessary that this range of responses be provided by any single agency. Some services would need to function through a number of the above service elements. Other services would be more equipped to operate through a single service element.

Although some services operating under the above framework may be perceived as particularly specialised in drug rehabilitation, in reality a range of services need to work closely together in order to achieve effective rehabilitation outcomes. For example, persons who avail of in-depth psycho-social supports to deal with deeply-rooted problems of addiction, might only do so as a direct result of participants having had prolonged contact

---

[54]   Prochaska, J., DiClemente, C. (1986) "Toward a comprehensive model of change" in W. Miller, N. Heather (Eds.) *Treating Addictive Behaviours: Processes of Change*, New York: Plenum Press.

with an outreach, harm-reduction service. Indeed participants may need the continued support of this latter service during future episodes of relapse. Continuity of service between different service elements is therefore, clearly important. In particular there is a need for mechanisms, both formal and informal, across the different services that allow for proper communication. There are basically two areas of practice requiring such communication mechanisms.

First, is the area of coordinated case management, which facilitates a professional discussion and sharing of information, as appropriate, of co-existing problems, cross referrals and other case-related issues. It appears that this particular area of system communication is quite underdeveloped and this issue will be returned to later in this report, both in the context of a specific discussion about TRP and broader considerations and recommendations.

The second area of practice requiring a communication mechanism is concerned with the identification of particular service gaps and the joint mobilisation of efforts in articulating and developing an appropriate response. Basically the TLDTF provides this mechanism by developing an overview of service provision within its particular catchment area. It is in the context of its discussions about service gaps that in its early stages the TLDTF, became concerned with the absence of services elements 1 and 2: outreach and treatment facilities for drug users, who mostly travelled 12 miles or more to the city centre for such services. The task force focused much of its early energies on supporting the provision of local treatment services. The energies and supports of existing community organisations and locally based practitioners were utilised in developing outreach and community-based treatment services, while meanwhile, the development of a central treatment clinic, for the whole of Tallaght, which would act as a resource and back-up to satellite, community services, is awaited.

In due course, the task force also became more broadly concerned with support and ancillary services and as a result of such discussions - involving a cross-section of drug practice personnel working across all of the above service elements - the need for community-based rehabilitation projects was and continues to be indicated. In particular, it was believed that a gap existed at Service Element 3 and 4 above and that new, designated community projects should be developed as a response to this gap. It was felt that a missing link in terms of local service provision was psychosocial support programmes that targeted drug users who had stabilised, through methadone or other, non-pharmacological programmes. It was felt that such programmes should focus on strengthening participants' capacities to overcome personal problems affecting their drug-use, and thereby complement the counselling efforts of health board workers and other services.

Importantly, it was also envisaged that drug-substitution facilities should not be part of such new programmes, although as already outlined, persons currently on methadone programmes would be encouraged to participate. Long-term it was hoped that such new programmes would assist participants to reduce and eventually eliminate their methadone intake and become drug free. This latter objective, which was incorporated into TRP's mission statement, reflected a continued belief, at this early stage of programme planning, in abstinence as the only effective route to rehabilitation. In practice, as TRP developed and took shape, the project embraced a more pragmatic approach, one that recognised that there were many and varied routes to effective rehabilitation.

In mid 1997 the task force set up a sub-committee with the responsibility of considering options for developing a new programme. The main work of the committee was to establish an overall management structure for one particular project and as result TRP was set up as an independent legal entity. The committee furthermore, secured a commitment of once off funding from TLDTF[55] consisting of a start-up grant of £80,000, to acquire premises and to employ a manager. In 1998 TRP decided to recruit a manager, who had a good background in addiction services and who could have a directive role in establishing a programme, developing its ethos and coordinate operational issues, particularly in relation to premises and budgets. It was envisaged that the committee would step back from directing the initiative and adopt a more supportive role to a suitable manager. The manager was appointed in June 1998. At the time a temporary office was provided for the manager at a community treatment facility, Jobstown Assisting Drug Dependency (JADD). TRP meanwhile was in discussions regarding the possible purchase of a vacant community building, near Tallaght town centre. However, after six months, for various reasons this plan was abandoned. There were legal difficulties concerning the building and its refurbishment costs were prohibitive. Furthermore, later in 1998 the health board established a satellite methadone service nearby and it was considered not a good idea to locate TRP's non-pharmacological-based programme alongside this new service. Following a fruitless search through auctioneer listings, a temporary base for the project was eventually found through the assistance of a local priest who offered space in a pastoral centre that is integrated with a chapel building. Discussions with community residents to alleviate fears in relation to drug projects followed, and additional funds were secured from the National Drug Strategy Team to facilitate refurbishment. A 6-year lease was secured at a nominal rent, and the project moved in to the premises in February 1999. In the meantime, TRP's manager established contact with potential programme participants through providing sessional counselling at JADD. As well as providing an opportunity to access the target group and recruit an initial set of participants, the manager's initial base at JADD also allowed her to be involved in a number of other important relevant, local initiatives.

During this period the project was also involved in negotiating funding for an attendance programme. Initial discussions with FAS envisaged funding a programme under Youth Training Programme (YTP) whereby the project would be designated a training provider and receive a *per capita* budget for training participants, who would be members of drug-user target group. However as YTP had an age restriction (participants must be under 30 years) this particular option was not pursued. At the time it emerged that a special category Community Employment (CE) scheme operated by FAS could be available for the area. This particular scheme has a lot of flexibility, in terms of entry requirements, content and duration, and in setting up a programme at the refurbished premises at St. Thomas's Church, it was decided to pursue taking this option.

Essentially the CE programme was designed for work preparation in a social economy. Participants must be long-term unemployed and on the live register. They are offered 20

---

[55]   Local drug task forces do not function as funding agencies. Rather, they compile a strategic plan for the development of services and responses in their geographical area. This development plan will include proposals for new initiatives and if these are approved the start-up finance is provided through the appropriate local statutory body, e.g. health board, vocational education committee, local authority, etc. Further funding for such initiatives becomes the responsibility of the respective statutory bodies and not the task force, subject, of course, to preliminary evaluation and availability of funds.

hours part-time work a week in sponsored projects. Typical projects might include security and maintenance of community buildings; the provision of community services (after-schools clubs, childcare, care for the elderly); community art projects, and so forth. At a national level trade unions play a role in vetting projects, thus ensuring they are not being used to replace workers already involved in mainstream services and also ensuring sponsored projects are not for commercial gain. Alongside a budget to pay participants there is also an allowance to develop a training component. In some programmes, additional funds from other sources are utilised to enhance this training component. In line with the National Drug Strategy the programme's qualification conditions and participation rules were made more flexible in order that the programme be utilised to facilitate the involvement of drug users in structured rehabilitation activities. A variety of CE schemes have been utilised for these purposes in a number of areas and TRP is one example of such utility.

Conclusion

From the discussion in Section 1 it is clear that TRP emerged within the context of new developments at both national and local levels in relation to drug problems and drug policies. In the main these developments marked a shift away from a traditional, abstinence or disease approach, toward a more pragmatic harm-reduction and community-oriented model. Section 2 above provides some insight into the way in which a local system for delivering and improving treatment and other services is forged through this new model. A framework embracing different elements of local service provision is beginning to emerge. It is clear that the various elements of this model are at an early stage of development, are quite fragile, and are hugely reliant on innovation and experiment. These different elements are also mutually interdependent, although it seems that this only really becomes clear as services expand and improve. TRP's development arises from the new system's need to provide drug users who have stabilised with structured psycho-social supports towards dealing with deeply-rooted personal and family problems and through this to strengthen their capacities to prevent a relapse to problematic drug-use. This basic aim is quite complex. Moreover, it does not easily lend itself to the intricacies of varied community demands. In due course it is the project's structured programme – which is outlined later in Section 4 - that constitutes its translation of this aim into reality. Meanwhile it is important to acknowledge that the project's emergence is intrinsically tied to a system of community support, not to forget an improved policy framework, as already mentioned. The local drugs task force, in conjunction with local health board personnel, have direct responsibility for initiating the project. Physically the project is hosted by an existing community institution. It relied greatly on a local treatment service in the initial stages of making contact with a potential target group and it was able to avail of a special category CE scheme in order to get started with its first group of participants. These varied levels of community support were critical in terms of getting the project started and providing it with a place and position in the community and clearly the project's future development remains linked to integration with this community system.

SECTION 3:
PARTICIPANT REFERRAL AND PROFILE

Alongside wider policy and social and community developments, as discussed in Sections 1 and 2 above, there is also a need to remain focused on the individual as being central to all treatment and rehabilitation interventions. Psychological theories of drug use causation emphasise the role of psychodynamics, social learning and stress-management, suggesting a variety of counselling and psychotherapeutic interventions that help to support and sustain individual choice, change and adaptation. The management of drug problems is, in many instances, linked to coping with the emotional states and craving that precipitate a return to previous patters of use and the focus therefore, of counselling supports, is often to assist in the development of strategies for the management and prevention of relapse. In due course the development of such strategies became the main focus of TRP's programme, and these include counselling, groupwork and the development of social support. These are key individually focused strategies for TRP's work, although, as outlined above, they operate within a social context that has been radically transformed. The operation of these will become more clear through a reading of Sections 4 and 5. In the meantime, Section 3 below, by way of providing deeper insight into the individual experience of drug taking and drug problems, profiles the persons who have attended TRP's programmes.

Three sources of information are drawn from in developing a picture of persons who are referred to and/or who participate on TRP's programme. First, the project keeps a master list of all referrals, including name, address, date of birth, date referred, referral agency and outcome of contact with the project. At the time of fieldwork for this report there were 61 persons on this list. Second, the project keeps individual assessment records of persons who are interviewed to participate on the programme. In all 43 assessment records were analysed in this manner for the purposes of this report. Also, two separate qualitative interviews were undertaken with each of ten persons who were participants on the programme during the period of fieldwork.

There are three stages of admission to project: referral, assessment interview and induction. Referrals are made to the project through a referral agency: health board, probation service, voluntary / community agencies. The project has no facilities for drop-in, once-off advice / counselling or advocacy for placement on methadone / detoxification programmes. Self-referral therefore, is rare and the project relies greatly for referrals on the relationships it and its staff has already developed both with prospective referral agencies and with some members of the target participant group. Furthermore, the project has developed an information-liaison with local agencies to keep them informed of the project's aims, its progress and to assist in the process of referral, as appropriate. On referral, in all instances, a letter is sent to prospective participant and copied to referral worker (agency) with a date for an interview appointment. It is not essential for prospective participants to have a referral worker *per se*. However, they must be linked in with some other service provider in order to participate in the programme, although, in practice, continuous ongoing contact with external service providers is infrequent, and needs further development, a fact that is recognised by project personnel.

In its first 18 months the TRP received a total of 61(35F: 26M) separate referrals from a variety of statutory but mainly community agencies. Most came from agencies with which TRP staff had managed to develop close working relationships. The project is located in a community setting and is therefore relatively easily accessible to persons from Tallaght. Although its actual location in one housing estate may lend justification to it being considered a resource for that estate only, it manages to draw participants from a broad community base. This reflects the project's efforts in community liaison and in particular its relationships with agencies that operate on a cross community basis.

Thirty per cent (18) of the first 61 referrals came from community treatment projects and 78% (14) of these came from adjacent treatment services, with the remainder from community treatment services elsewhere in Tallaght. Twenty-six per cent (16) referrals came from a non-treatment community drug project that serves the whole Tallaght area, and similarly eighteen per cent (11) came from a community family service for Tallaght. Sixteen per cent (10) referrals came from statutory services, 50% (5) of which were from statutory drug services. A further 10% (6) came from miscellaneous sources including 5% (3) self-referrals.

As already mentioned, a number of target participants were already known to project personnel, prior to referral. Other participants got to know of the project through contact with friends who were already on the programme. Alongside formal referral therefore, there is a gradually developing informal network that also acts as a mechanism for facilitating referral onto the programme. For example, the project's support / outreach worker is not recorded on assessment forms as a referral source. However, in interviews conducted with current participant group, some indicated that it was through direct or indirect contacts with this worker that they first heard of TRP and were eventually referred to the programme.

> I met her *(outreach worker)* one day then in shopping. I was in the square and she said to me about this place was open and I'd seen her once or twice before and she knew that I was kind of stable and every time she was bumping into me now I wasn't kind of groggy or anything. So she was saying how are you doing and I told her and she said well there's a place up there that's being run on a CE scheme that would probably be good for you, its rehabilitation and she told me all about it so she said to apply. So I came up, I think she was saying that there was a couple of places and I applied, I got induction and then I got to stay (Fiona) [56].

> So when I moved up here and then *(Name)* was telling me she had a lot of problems with her kids took off her and she was saying I'm after getting on to a course. And I said what because I knew she's a lot, through the years you know hearing stories around town, her kids, I'm getting my kids back, I'm getting a life, how did you do that and she was telling me through this project. Like they were the first participants, it only opened last year and I said how is that so she was telling me and I went down to speak to *(outreach worker)* (Pamela).

Following initial referral, all prospective participants are offered an interview for assessment onto the programme. Support / outreach worker undertakes the initial interview and it focuses

---

[56]   For the purposes of quoting fictittious names are assigned to programme participants.

on establishing levels of stability with respect to use of drugs and basic motivation for participation. The interview also deals with administrative matters concerning qualification for participation in CE. Persons currently in insured employment do not qualify. Persons must also be on the live register of unemployed persons and be resident in the catchment area of postal district Dublin 24. In the event of a no-show for an interview referral worker is contacted for a follow-up and a second interview, may, if it is desired, be arranged. Of the 61 persons who were referred to TRP in its first 18 months, 53 (31F; 22M) (87%) were interviewed and 8 (4F; 4M) (13%) did not show.

Following assessment interview a discussion is held at next staff meeting and usually an offer to participate in induction is made. This offer would not be made in instances of frequent use of benzodiazepenes, methadone daily treatments of 120ml or greater or in circumstances where assessment interview appointments have been repeatedly missed. The decision to offer induction therefore is clearly based on an assessment of prospective participants' abilities to actually turn up for programme sessions, to contribute and not to disrupt. Of the 53 persons who undertook assessment interviews, 33 (21F; 12M) (62%) were offered induction. The remaining 20 (10F; 10M) (38%) were not offered induction, for reasons relating to their current drug intake or inability to demonstrate a commitment to regular attendance.

Induction is structured over a three-week period during which participant is not registered under CE. Participation is gradually developed from 2 sessions in first week to 6 sessions in third week. The initial emphasis is on one-to-one work, participation in activities leading to participation in open sessions: breakfast and coffee break (see next section for programme outline). Staff members constantly monitor participation and exchange views and ideas during coffee and other breaks. In circumstances where staff are unsure of a person's suitability to the programme the period of induction might be extended for a further three weeks. Otherwise, a full place on the programme is offered or not.

> ….induction that's it, come in for your induction 3 days a week for a few weeks and then you go on a months probation, you come in full time for the month then and then you re told if you get it or not, now it took me 2 months which is probably another factor actually the board knew as well because at the first month I'd a few problems. I just wasn't getting with it, I was argumental. I was just, didn't want to see life, didn't want to really look at myself, and I found it very hard at the start. I was very aggressive at the staff and as I said I thought it was us against them kind of thing, when its not really, the staff are…it's an unusual place. Like most places I've been in even around drugs its always like there's the workers and us and them kind of thing and its not up here, but that's the impression I had when I came in. It was like the workers and they were, well not enemies but they weren't friends anyway but that's the whole thing in the end of it, they are friends and they're very helpful towards you and they help you out (Tony).

Of the 33 persons who participated in induction, 30 (19F; 11M) (91%) were offered a place on the programme. Three (2F; 1M) (9%) were not offered a place on programme following induction, for reasons relating mainly to attendance and an inability to make the necessary commitment to the programme's routines.

Of the 30 who commenced the programme 19 (14F; 5M) (63%) were considered to have been successful placements and of these, 9 (7F; 2M) (47%) were granted a six month extension of the programme after first 12 months; 5 (3F; 2M) (26%) completed the programme without an extension; 3 (3F) (16%) left the programme early with the agreement of programme staff; and 2 (1F; 1M) (11%) became deceased during the programme.

The remaining 11 (5F; 6M) (37%) were considered unsuccessful and either discontinued or were asked to leave the programme. The reasons given by the project for asking persons to discontinue, include:

- A lack of ability to understand, or participate in, the programme.
- An inability to adapt to the programme's structure and routine
- An inability to attend on a regular basis arising from health considerations.
- An inability to attend on a regular basis arising from homelessness.
- Serious relapse into problematic drug use with consequent behaviours interfering with day-to-day operation of the programme.

In some of these instances either a probation period might be extended or some other mechanism used to re-direct or re-focus participants' engagement with the programme. However, if issues continued to be not addressed, then a participant would be asked to leave.

Age

The mean age of all 43 persons assessed is 25.4 (SD=4.3; range = 19-37). Females (25.0 [SD = 4.0; range = 20-34]) are slightly younger than males (26.1 [SD = 4.6; range = 19-37]). There is very little variation in the mean age of both successful and unsuccessful groups: 25.1 (SD=4.0; range = 20-34) and 25.7 (SD = 4.5; range = 19-37) respectively, with a slight indication of youth for the successful group. Some variation in age between males and females is evident in the unsuccessful group, where the mean age for males is 26.5 (SD = 5.2; range =19-37) and that for females is 24.8 (Sd = 3.6; range = 21-33).

Gender profile

The project has a clear female gender tendency. Fifty seven percent of referrals are female; 63% of persons offered a place on the programme are female; and, 74% of successful participants are female. The current participant group is mostly female; all of who have children. There were four separate pregnancies among female participants since the programme started indicating perhaps increased levels of stability for women, while on the programme. It seems clear that financial and childcare considerations operate to attract young women, as primary child carers, although, as is evident from discussion in next section, there are other motivations also:

> Women don't lose anything to come here. They still get paid on their book. So that is probably why there is more women. The boys have to sign off their labour. For girls that have kids its great, they have their book and their wages from here (Margaret).

I was doing well. I was sticking to my methadone and not missing my clinic…I was getting organised…. and I was saying now all I need now is a few bob that I can start doing a bit in the house or do you know what I mean so the extra £120, I know its not much but if I needed to get in whatever I could start putting money away and getting things in, that was all that was kind of missing, but then when I was here a while I realised well I've to look at all myself, all of that (Fiona).

You get used to the money. I knew when I was starting here it was only for a year and there was a chance of extension but I won't get used to the money. I give my Ma my book and that way she can sort out nappies and things. And minding the baby. And the money I get here is saved and I get what I need. But you do get used to it. (Alison)

Because money being an incentive, this accounts for majority here who are women. But, I know that it is other things that hold people here. Women with small children don't want to be on methadone for the rest of their lives and they are highly motivated to explore other possibilities (staff member).

The absence of similar financial incentives for men may provide some explanation for low male participation, although, as is the case for at least one male participant, who commenced the programme shortly after leaving a full-time job, financial considerations were unimportant.

I know my fella wouldn't come up here for £10 a week on top of his labour. Do you know what I mean? There's not a hope in hell would he sit up here for 20 hours a week for £10 (Fiona).

To me it's not about money. It's about getting myself together…..I know I could have went straight into another job, like I had an offer of a job straight away but I just said no, I think I better work on myself first (Shane).

The female gender tendency is also evident in the assessment data on 43 (25F; 18M) persons, which was analysed for this report. This data can be divided into two groups. First there is a successful group of 18 (42%) (13F; 5M) consisting of persons who were successful on the programme as already described. Second, is a non-successful group 25 (58%) (12F; 13M) consisting of persons who were not successful or not offered a place on the programme, following assessment. While females make up 72% of the successful group, they make up less than half (48%) of the unsuccessful group.

Living status

Eighteen (45%) of 40 persons assessed reported they were living in rented accommodation. Only two of these indicated local authority rental, so it is assumed remainder are in private rented accommodation (this probably needs to be checked). Sixteen (40%) were living in their family home. The remaining persons assessed stated that they were living in their own home (2), in their partner's house (2), with friends (1), with sister (1) and other (1). Three persons provided no information.

A little over one fifth (9: 7F; 2M) (21%) of 32 who provided information, reported they were living with their partner, and females were more likely to report this. On the other hand males were more likely to report living in family home or with family member; 5 (80%) of 10 males who gave this information stated that they were living in their family home as compared with 9 (41%) of 22 females who provided this information. Some of these percentage differences are accounted for by larger number of females overall and also a greater number of males not wishing to provide this information. Finally 5 (11%) of 32 persons reported living alone and all were females.

The majority of persons assessed (25) (60%) reported that they had children. Unsurprisingly, analysis revealed that females were significantly more likely then males, to report this (x^2= 16.04; df=1; p<0.01); 85% (21) of the women reported having children, compared with 23% (4) of the males. Given the programme's female gender tendency it is also unsurprising that the successful group are also more likely to have children: 72% of 18 compared to 50% of 24.

Education and employment history

The mean age at which persons reported leaving school was 15.5 (SD = 1.2; range = 13-18). There are no gender differences and the only variation across successful and non-successful groups is that male successful group members (5) reported a slightly higher school-leaving age (16.0) than their non-successful counterparts (10; 15.3).

Females were more likely than males to have left school without qualification; 38% of 24 as compared to 11% of 18. Conversely males were more likely than females to have left school with Group, Inter or Junior Certificate 13 (72%) as compared to 10 (42%). However, a higher number of females (5) (21%) reported having their Leaving Cert as compared to males (3) (17%). There is a clear variation in educational attainment across the successful and non-successful groups with respective percentages of 12% (2) and 36% (9) for those who left school without a qualification. Fifty-eight per cent females (7) in the non-successful group left school without a qualification as compared to 17% (2) in the successful group.

Fifty per cent (18) of 36 individuals assessed reported having some employment history. There is a clear higher level of previous employment in the group who were successful on the programme with 12 (80%) of 15 reporting previous employment experience as compared to 6 (29%) of 21 in the non-successful group. The data available on previous employment are limited, but people reported a diverse range of jobs including, chef, waitress, factory work and working in a bank. In addition, one fifth of persons (8) who were assessed stated that they had previously done a CE Scheme and an additional 5% (2) had been on a FAS course.

Drug history

The mean age at which persons first used drugs is 14.1 (SD = 2.0; range = 10-19) with over half the group (51%) having commenced their drug use before the age of 15. The mean age was slightly younger for males (13.7 [SD = 2.2; range = 10-18]) as compared to females

(14.4 [SD = 1.9; range = 12-19]). The variation in age of first drug use across successful and non-successful groups is insignificant.

Regarding first drug used, a diverse range of substances is reported and most people' (28) (64%) report the use of more than one drug when they initiated consumption. Almost three quarters (31) (73%) report cannabis as their first drug of use. This far exceeds the percentage who report alcohol as being their first drug(15) (34%), which may be due to different interpretations of 'drugs'. Nine per cent (4) report that the first drug they used was heroin. One person reported other opiates (methadone) as the first drug of use. Others initiated their drug using careers with the consumption of LSD, 5% reported first using XTC and 1% amphetamine.

Information on the main drug of addiction was also collected. Fifty per cent (22) report heroin as being their main drug of use and 48% (21) report methadone. A higher proportion of successful group (67%) (12) than of non-successful group (40%) (10) indicated heroin as their main drug of use. Analysis revealed no gender differences in the choice of primary drug. The mean age at which clients reported first using their primary drug was 18.5 years (Sd=3.5; range 14 to 26 years), although not statistically significant men initiate use of their primary drug a slight younger age (mean=17.5 years) than their female counterparts (mean=18.9 years). Eighty-two percent report the use of additional drugs such as XTC, followed by cocaine, amphetamine, benzodiazepines and heroin.

Information on injecting is also collected during assessment. Eighty per cent (35) stated that they had injected drugs in the past. Analysis revealed that males were significantly more likely to report this compared with females (x^2=4.15;df=1;p<0.05). Ninety-five per cent of males (17) reported having injected compared with 68% (18) females.

The mean age at which injecting drug use was initiated was19.4 years (Sd=3.3; range 15-29 years). Although not statistically significant males initiated injecting drug use at a younger age (mean 18.7 years; Sd = 2.6) than females (mean =19.9 years; Sd =3.9). Similarly, members of the programme's non-successful group also initiated injecting at a younger age (18.5; SD = 2.8) than the successful group (20.1; SD = 3.8). Regarding risk behaviour, 71% of those who reported injecting drug use, reported having shared needles at some point in their drug using careers.

Over one third of (15) persons assessed reported having a partner who was an injecting drug user. Analysis revealed that females were significantly more likely to report this than males (x^2= 13.31; df=1; p<0.01); 61% (4) of females reported having a partner who was an injecting drug user compared with only 5% (1) of males.

Eighty-eight per cent of persons (39) assessed reported that they were on methadone. There was no gender difference in this regard. The mean length of time on methadone was 2 years, however the range was very broad with one individual reportedly on methadone for only 4 weeks and another on methadone for 6 years. Just over one quarter was on methadone for less than 6 months, 14% were in receipt of methadone for between 6 months to one year and 60% were on methadone for over a year.

Similarly the levels of methadone consumed by clients varied greatly. The mean dose of methadone was 56mls, median dose was 50mls and the range was 10mls to 114mls. Analysis revealed that there were no significant gender differences in reported levels of methadone consumption.

At the assessment, limited data is collected on current consumption of drugs, other than methadone. From the data available only 15% (6) reported being on other medication, however an additional 7 (16%) reported that they used benzodiazepines, and in these instances it is presumed that these drugs were not prescribed. Over half (60%) of the persons assessed reported that that did not drink alcohol, 3% said they drank rarely, 26% occasionally, and 3% regularly and 8% reported heavy use.

Three quarters of persons assessed reported having had a detoxification in the past. Analysis revealed no gender differences in this regard. The number of detoxifications reported ranged from 1 to 11, with a mean of 3 detoxifications. From the available data 8 reported a self detoxification, 1 reported attending Trinity Court, 4 reported detoxifying in prison, 2 reported attending Cuan Dara and 1 attended Aislinn. In addition 23% (10) reported having previously been in rehabilitation: in Coolemine (2), Aiseiri (1), Cuan Mhuire (1), Merchant's Quay Ireland (1), the Rutland Centre (1) Saol (1) Target (1) and Victory (2).

Data from qualitative interviews with current participant group add further detail to participants' drug history. Many of this group have quite serious poly-use problems. The mean age of drug initiation is 15, with 12 as the lowest age of commencement. The participant group have a mean drug use career of 12 years. Early drug initiation is associated with both availability / opportunity and personal problems.

> I'd say I started smoking hash and doing LSD around 13, 14 and then within a pretty quick period of time I was doing physeptone…. that's actually what I started on and naps, MST and stuff like that….. I was doing it every day and not thinking I had a problem and then heroin came on the scene, for me it just seemed to come out of nowhere…..I was buying locally in Tallaght. I used to actually meet a fella down at my local chemist and he'd get his physeptone out of there and go round the corner and sell it to me or whatever…. At the start heroin you'd be going to *(outside area)* but it was just, you just had to jump off the bus and there it was, thinking back on it now it just was like all of a sudden it was there like and loads of it everywhere (Tony).

> I was 13 when I had my first joint. I thought it was brilliant, there was a lot of stuff going on at home. I wasn't happy at home, and I think I was hanging around……. I just started smoking it and I loved it. I think it was more because I was out late and was in trouble. I just didn't want to go home. That was relaxing. But I didn't care. And I went home and my Ma and Da were still up and I was like f…k off. I don't know, it just freed my thinking about what was happening at home, am I going to be in trouble? I just enjoyed it. It started from there………From about 13 to 17 I kind of jumped from one thing to another. I never stayed with the one thing. I would swap over. Then I started smoking Heroin (Alison).

Later initiation into drug use is associated with loneliness arising from separation from drug-using partners, caused by death or imprisonment and for at least one participant, methadone was her one and only problem drug.

> I started having a smoke, never intravenously and not really realising that it was going to get a hold so quick. It was just that I'd never been away from him. We were living together and I hadn't even really got many friends, apart from work. I used to work in town but I hadn't got anybody up here so I kind of stuck to one girl and she was smoking gear at the time. I ended up having a few smokes and before I knew it then it had hold of me. So I'm on methadone now nearly 2 years and I'm detoxing, so going well (Fiona).

> I got addicted to Methadone, not Heroin. I was very stable when I came here…..I very rarely dabbled with heroin or anything like that. My first preference drug would be methadone (Michelle)

While the current participant group have considerable drug problems, the group is generally perceived by project staff as highly motivated and not as distracted, as might be expected, by the draw of illegal drug-use. They are particularly convincing of their desire to change, even if they often come across as unsure of how to bring this about. It appears that within their own families there are others – mostly partners – who have more serious drug problems and who are not attending similar services.

Because of their drug histories project participants tend to carry negative self-perceptions of their role and value in the community, although it is evident that for some participants drugs have played a more important role in their lives than for others. Participants also differ in their degree of stability – although significant levels of stability are required for project referral - and their determination to overcome the influence of previous drug lifestyles.

> You need to get rid of old friends. That is why I would go back to it (drugs) That is the one good thing I have got out of here, I am stronger. Say no, and not let them (friends) in. But really some of them probably would have been giving me drugs. I never stop trying. Sometimes I think am I ever going to get over them (Jennifer).

Generally, project participants lack a history of meaningful adult experiences outside of drug-use: their work and educational experiences are low and they lack an involvement in formal social, cultural or recreational activities. This is often reflected in their slow adjustment to project structures, usually taking up to three months for participants to settle and become conversant with the programme's content and objectives.

> …when I first came in here I was still in very much denial; no I'm not an addict. I'm not strung out, I can get off if I want to ….But when I got in here I was always, I was participating in every session. I loved it but I was still saying I'm not like them. I haven't got this problem but yet I knew I had this problem. And the sad thing about it took me 6 months before the penny dropped…. but that was a very, very hard thing for me to accept (Pamela).

Alongside drug problems, participants also generally present with relationship issues linked to their drug problems and arising from isolation / loneliness, not being able to connect with people outside the drug scene and experiencing difficulties maintaining relationships. Most are in relationships with drug-using partners, many of whom are on methadone treatment programmes, and in some instances participant's *serious* drug-use commenced sometime

after such relationships were initially formed. Some also have experienced serious traumas and bereavements and require a lot of intensive support

> I've had so much tragedy throughout my life, I'm only 30 and I've lost so many people to drugs or to illnesses and I just feel that I've never grieved properly for these people, they were all so young and my family as well, members of my family but yeah I just feel that I've never grieved properly because I was on drugs, I was always on drugs from the start, from when they started dying, from when my father died I was only 13 so (Shane)

Medical issues

Over half (24) (63%) of 39 persons assessed reported having no medical illnesses at the time of their assessment. Females were more likely to report no illnesses; 74% (17) of females reported no current illness compared with 47% (7) of males. Fifteen per cent reported having asthma; 3% reported having epilepsy and an additional 18% did not specify the nature of their physical illness (7). However, an additional 18% of the those assessed (8) reported that they had hepatitis C. Analysis revealed that male clients were more likely to reported having hepatitis C then females, as three quarters of those who reported being HIV positive were male. Finally, 32% reported having had a psychiatry history, although there was no significant gender difference in this regard, 29% of the male client reported a psychiatric history compared with 27% of the female clients.

Conclusion

The above section has been concerned with providing a profile of persons attending the TRP. To date the project received 61 referrals of whom 30 were offered a full place on the programme. An analysis of participant profiles was undertaken through an examination of assessment data (43) and qualitative interviews conducted with ten current participants. The mean age of persons assessed for the programme is 25. There is a clear gender bias among participants: mainly young women, all of whom have children. This gender bias is facilitated by social welfare rules that make it possible for lone parents to retain benefits (including income, housing and medical card) while they receive an extra allowance for programme participation. Gender differences are apparent in relation to individuals' living status: women tend to live with a partner or on their own with children, while men tended to lived in their families of origin. The mean age at which persons assessed left school was 16: generally males were more likely to have qualification (iner, group or junior cert), although more females had qualifications at a higher level (leaving cert). Fifty percent of the group had an employment history: those who were subsequently considered successful on the programme experienced higher levels of employment. The mean age of first drug use was 14, with over 50% of the group assessed having commenced their drug use before age 15. Cannabis was first drug of use for nearly three-quarters of the persons assessed. Ninety eight percent reported opiates (heroin and methadone) as their main drug of addiction and the reported mean age for first use of primary drug is 19. Eighty per cent reported injecting drugs in the past. Over one third reported having a partner who was an injecting drug user. Eighty-eight reported that they were currently on methadone The mean length of time on methadone at 2

years, although this ranged from one month to 6 years. The mean dose of methadone was 56 mls (ranging from 10 – 114 mls.) There are clear poly drug use problems with programme participants and they report a range of associated problems, mainly involving relationships with partners, familiy members and friends. Participants have also experienced a lot of trauma and bereavements arising from their involvement with drugs and relationships on the drug scene and some also reported having medical problems. The overall picture of participants is young, mainly female, with children, with serious drug problems over most of their youthful years, with relationship difficulties (mainly with partners most of whom are drug-using and not in rehabilitation) and also with negative feelings and anxieties associated with their lifestyles arising from their use of drugs.

SECTION 4:
TRP PROGRAMME AIMS, STRUCTURE AND CONTENT:

TRP operates a 12-month, half-daily, attendance programme for drug-users: 20 hours per week, mornings, Monday-Friday. The target participant group is drug users in Tallaght who have stabilised either through methadone maintenance or non-problematic drug use and who express an interest in dealing with their drug problems. The programme content is a mix of structured and unstructured practical and therapeutic components. Although TRP, as already described, operates as a CE programme, its primary focus is therapeutic intervention and the programme is not considered by TRP as a form of work. There are seven members of staff on the programme: a manager, senior project worker, programme supervisor, project worker, outreach / support worker, housekeeper and administrative assistant. Drug users on the programme are referred to as "participants" or "clients" and not as "trainees" or "employees"[57].

The overall aim of TRP is to get participants to address the causes of their addiction to drugs and to make changes, at a personal level, that would help them get on with their lives without a drug dependency. The project is described as a place, devoid of regular street-drugs influence or the influence of drug treatment monitoring, in which drug users can reflect on their past and seek support.

> (Our aim is) to take chaos out of their lives through providing a safe space to be able to work on themselves and through doing this to develop their sense of belonging and to provide practical and emotional support (staff member).

> People feel safe about being here and in the knowledge that it is not in any way caught up with the organising of their medication (staff member).

> (The aim is) to help them to re-build their lives constructively and to look at the issues that have led them to coming here. The drugs have blocked out so much of their teenage years, so there is a real need to get them to look at their addiction (staff member).

> Their initial expectations in coming here is to get answers to why they have been using: they are looking for answers…They go on this inward journey of discovery, learning to move on – for some it takes a long time – it takes a huge amount of work. It's very stressful for them because it is about them learning how to let go (staff member).

The project emphasises the need to help participants return to normality: developing their self-respect, developing basic skills and helping them to deal more effectively with practical issues in their daily lives.

---

[57]   For the purpose of this report the term "participant" will be used.

> Our aim is to work with people, to give them an opportunity to get confidence, to get a bit of experience, regardless of the addiction. It's about providing opportunities, a bit of learning. Confidence is really big (staff member).

> (The aim is) to give them a leg-up through coping skills and self-development, life-skills and through dispelling their fears; to have an income and to give them a positive attitude towards education and work; to improve the quality (of life) in even the smallest of ways for participants (staff member).

> (The aim) is to help them to get back into the real world through education, relapse prevention and being able to get out there and get a job (staff member).

The project also emphasises the need for participants to address and improve their relationships with important people in their lives – family, friends and neighbours.

> They have burned a lot of bridges in the community and with their families. This place gives them an extra bridge to develop. A lot of them would have been excluded from their estates and their families prior to coming here. The role we play is in helping them to rebuild links and structures with their families and through this they get involved in other (community) projects. It is a slow process, a very difficult process and it takes time to put together. These things stay in place and can be worked on – they are an opportunity to renegotiate their engagement with social, personal and educational services (staff member).

> We focus on how they are dealing with family relationships, the practical things, and communication problems. Difficulties in communication are linked to their own personal drug-use or that of their partners. (We get) some movement on family communications as a result of discussing things in the group (staff member).

> Because of their shared histories, they carry a very negative label from within their community. They have a lot of life and death experiences and they have a lot that needs to be passed around, requiring a lot of intensive support (staff member).

As mentioned in Section 1, TRP emerged in the context of evident therapeutic gaps in community service provision, following the expansion of drug treatment services in Tallaght in the mid to late 1990s. In this regard, programme aims tend to be described in terms of what can get offered in TRP as distinct to what might be provided in treatment services.

> Some users in treatment centres need to be given the extra bit of a push out of their comfort space and helped to overcome their fear of the unknown and take up new challenges. That's the difference in what we do here: we push them more (staff member).

> I've seen people come in with very little self-respect and I have witnessed a turn around. I have a sense that this project has been the missing link – with all the treatment there was no follow-on (staff member).

> There has been some sort of shift that says 'I need to be able to go further.' Their treatment is not helping them with what is going on (in their heads). Here, we are helping them to address these issues (staff member).

The project's tendency to make a distinction between what it and drug treatment services provide, reinforces the way, as already mentioned, recovery from drugs is seen as leading to drug abstinence, including abstinence from legal drug substitutes. However, in pursuing its overall aim, the project has made pragmatic adaptations to the realities of drug dependency, especially when these are viewed from within the wider context of serious social exclusion. In many respects these adaptations happened as a result of the manner in which the project has developed its programme. It has very clearly emphasised an eclectic approach to programme development: working across a set of parameters, but keeping these relatively broad and valuing the contribution participants make to group maintenance and overall programme development. Also by engaging in an ongoing review of its work and in adjusting and modifying the programme according as it developed, made mistakes and heard feedback from participants, the project is able to maintain this openness and flexibility to programme development.

> What keeps the programme together is the bonding and support from within the group and the staff holding it together, keeping it ticking over and monitoring the safety (staff member).

> We achieve these aims primarily through participants' involvement: ongoing consultation and constant evaluation of programme sessions (staff member).

The project consequently is now more focused on improving participants' quality of life, developing their self-esteem and confidence and enhancing their learning, problem-solving skills and ultimately in improving their ability to prevent a return or relapse to problematic drug-use.

> …. Its just to get us out into the real world and get us used to that we are a person…. (to) get us used to what we are. We've always lost our confidence out there and get all that back instead of looking well I'm a junkie, I wouldn't be as good as her, you know all this (Pamela).

> I wanted confidence, everything in my life, when I first came here I wouldn't go anywhere without bringing the baby with me or bringing someone with me. But now I can go places and talk to people without having someone with me. That was basically it, confidence and self-esteem (Alison).

> I have been clean now for 12 months, off everything bar my methadone. I am only on a small dose. I am coming off it; I am getting a pain in the arse taking it. I don't need it. But I want support in that and I want support to be able to deal with things that happened to me over my childhood years. I think its mainly I want to work on myself and be able to, not love myself but like myself. Not hate myself because of what I have done and whatever. I think its mainly support and for myself. I want to be able to work on myself (Margaret).

> (I wanted a) bit of an insight into myself, I suppose at the start it definitely was like kind of why did I use drugs, why did I take this path? And then as well maybe to set myself up for the future, having a look at myself. I didn't expect what it was going to be because I never could. I don't think anyone could have expected like the way the groups worked and all, blow your mind you know (Tony).

I knew that the way I was living there was something wrong with it, to be honest I didn't know what was wrong. I just knew there was something with the way I was living and I wanted to get off Methadone and I have tried several times myself a detox…. So I just know that the way I was living wasn't right. I didn't want to be on drugs for the rest of me life but I just didn't know how to come off it. I wanted help so I came here and I really didn't know what I was going to expect (Michelle).

Programme structure

Providing a routine, daily structure is a huge part of TRP's programme and this is many ways, does distinguish it from say outreach, treatment or drop-in services. The daily structure is planned and predictable and an important element in the programme is to tie participants into such structure as an alternative to the disorder that is often associated with their former lifestyle.

> The structure is a huge part of what is on offer here. They (participants) have a reason to get up (out of bed), somewhere to go, a routine, and a commitment. They have guidelines to work with and they are comfortable with this because they lack a structure (staff member).

The programme's structure is educational in the sense that it is scheduled and through this schedule participants get exposed to new ideas, knowledge and experiences. It is also challenging, particularly at a personal level, supporting participants to explore their history of addiction, to identify internal reasons why they became dependent and learning new ways of dealing with stress and difficulties in their lives and re-building family relationships and friendships. Through attending the programme participants develop a new routine: arranging child care and getting to the project at regular times, gradually creating a structure around their daily lives that contrasts with the more familiar chaos associated with their problematic drug use.

> I look forward to coming up everyday. I do enjoy the actual things we do, most of the stuff we do. At first I was kind of wondering what's bleeding drama got to do with getting your head together but then when I said it to my key worker it was all explained to me kind of thing and I said yeah I understand that. Like the computers for example there's a certificate and stuff at the end of that which you can put on your CV and the same with the photography. I was thinking as well photography what has that got to do, but its all preparing you for when you finish the course. You get certificates that you can put on your CV, which is a good thing to have (Shane).

> ….you would be surprised what you find out about yourself. That is what keeps people here, to find something they like and get a taste of good things. I think its how far you are in your addiction and how serious you are about getting off it. How willing you are to put up with everything. Good and bad. If you are not willing to put up with the bad then there is no point (Alison).

> TRP has helped me to talk about my feelings, being able to talk honestly with my parents. I have an amazing relationship with my parents and my ma. I used to always think when I was a teenager Jesus what the hell is wrong with that woman, can't wait to get out……I never thought I would have a relationship with my ma, I really didn't, all

through my drug years I fought and fought like cat and dog, she was very sick and all through worry and stuff like that. It didn't bother me. Now, I'm not wracked with guilt over it (Tony).

The role of staff is to develop and sustain a supportive, nurturing environment. Primarily, they do this by creating a peer-bonding and support system and then maintaining this system through interacting with it, enhancing it, challenging it, suggesting changes and re-directing it when it becomes unsafe. Building participants' motivation is a key component to the programme. Participants regularly slip in their motivation and staff try to assess and monitor this, putting an extra effort with somebody whom they believe is feeling down and on the brink of returning to drug use.

If somebody is depressed, feeling poorly ….. It's never let slide. It's always picked up and followed on (staff member).

Participants' motivation and commitment is sustained through their participation in the daily programme.

The project emphasises self-development through communication, drama, computers, weekly meetings with co-workers, swimming, going away weekends – this is self-development. The very fact that we all sit down together for breakfast – this is where self-development starts (staff member).

This daily routine is built around two main group sessions, but it commences through a very important morning breakfast. From 10 o' clock each morning participants arrive and have a hot breakfast along with members of core staff. Breakfast is self-served from table platters according as people arrive. It is a particularly important mechanism for facilitating new entrants onto the programme.

We have breakfast at 10. I like that, everyone does. You get to sit down and talk to everyone for a while (Jennifer).

Your first meeting with the group is at breakfast and it depends on how you are at breakfast whether you go into a group then or not. Or if you need another couple of breakfasts for time to settle in…. It's nice to have a chat and a laugh. I think that is why they use the breakfast for the first time, then you go home after it. It is a good way to start you off. Just sitting there chatting. And you could say to them I am not ready yet, I will come for breakfast again. Sometimes they know. They watch how you get on at breakfast. If you are relaxed you can start. That you are not just in have your breakfast and go home. And not talking. You can tell who they have to bring in slow and who they can just bring in at normal pace. I think that is brilliant, I would rather someone said to me you are not ready. Its good that they check up on what you are doing. (Alison).

Conversation during breakfast is unstructured, open and robust. It initially involves greetings and informal exchanges about current personal events or people. Staff adopts both a directive and non-directive approach to this daily event. On the one hand they maintain basic breakfast rules, such as timekeeping and ensuring conversation is not glorifying recent episodes of drug use. On the other, staff encourages participants in various small, informal group formations,

to engage in discussion about themselves, their families, pending problems or difficulties and their overall progress both in and out of the programme. Staff spend a lot of time observing and listening, trying to understand what changes and developments are emerging, building up a daily-picture of each participant's progress and processing this in further staff discussion by deciding whether a participant needs extra attention or needs to be challenged on any particular issue.

> I sit at the table with them at breakfast. My starting point is wondering how they got on since before I saw them last. I might ask: ' What type of day or weekend have you had since I saw you/ How are your children?' If they are not ready to talk you leave them. I spend a lot of time listening, trying to ascertain their likes and dislikes (staff member).

> As a result of breakfast discussions, we would raise issues at staff meetings and how things might be followed up more. We use our observations and our discussions to build up a day-to-day picture of what's going down. These get passed on to key worker who is then able to deal with them privately (with participant) (staff member).

Groupwork

Between 11 o' clock and 12.30pm the main group session of the programme takes place and two members of staff jointly facilitate this. Three days a week this group consists of a drama, art, video or other activity. For the other two days it is focused on relapse prevention discussions and exercises. There is a break for coffee and smoke in between group sessions and like the morning breakfast, this coffee break is peppered with a lot of information, conversation, with staff playing a non-directive role in stimulating and facilitating discussion. An activity group follows coffee. This group might be a continuation of a drama or art session or consist of an input (lecture / workshop) by an external tutor dealing with health issues, welfare issues, computer training etc. Participants leave the project at 2.00 PM.

Occasionally the programme also involves outings for swimming or hill walking thus providing opportunities for participants and staff to do something together away from the Centre. Similarly, an occasional residential weekend is organised. As these take place on a self-catering basis in suitable rural locations they provide good opportunities to support the development of supportive relationships.

Among the main group activities are drama exercises, providing opportunities for participants to play games, to have fun, to laugh together in the context of a high energy session, which draws out physical energies. It also draws out participants' creative sides helping them to find new forms of expression for pent-up feelings and frustrations. The drama is also used to encourage the group to develop as a team thus strengthening its mutual support system. Other activities include communications courses; computer courses and courses on parenting skills. There are also occasional workshops dealing with health issues and sexuality.

At various stages programme participants are invited into an ongoing review of progress, evaluation and planning of groupwork sessions. There is a lot of attentiveness, questioning and clarifications in this group. Much of the work is undertaken in smaller groups, thus

generating a lot of interaction, with each other although some members require a lot of individual attention from group leaders. Participation is generally good although, as in any group, a few participants will always dominate the discussion. There is willingness by group members to share responsibilities in group development: introducing the group to new members; recording notes on a flip-chart; thanking other members for their contributions.

> Say there's someone in for 10 weeks. The next week we sit down and we evaluate…. and we'll put up (on flip chart) like we'll brainstorm it, good stuff and get everything out. And everyone has their say on what they felt and should they have done this, should they have done that which is very good. We do that for everything we do and we had one there this week about how to improve relapse prevention and stuff like that so it was very good…..(T)he good thing I suppose, it's not like being dictated to us to this, do that. We have an input at the end of the day…… a lot of the stuff that we do and all we'd have a say in it. And it would be down to us if its bad or not, so it would be on our heads as well as the staff and its good to have a bit of an input like that, makes you feel that your being listened to (Tony).

> If we don't like something that is happening, if it has to happen we have to stick with it for as long as its going on but then we can go back to what we wanted to do. Some things do have to be done; there is a rota. And then if we don't like it we just stick it out and then go back to what we want to do (Alison).

Relapse prevention

Twice a week the group focuses on relapse prevention. In this session members share accounts of recent efforts to resist becoming drawn back into a drug scene, and also recount moments of support and encouragement from family and friends. The group is built around a sharing of emotions and feelings in relation to drug-use and drug-avoidance. Although the group itself provides a regular structure for this, participants can also use other mechanisms within the programme for discussing relapse issues.

> ….if you do have a relapse you say so. You really need to talk about it, rather than keeping it to yourself then it gets worse. Because you are hiding it from the group and not getting help. So you are multiplying it in your head, and before you know it you are into another relapse. Its harder to get out of the second one. You are better off saying I had a relapse. But you don't have to wait until the relapse prevention group; if you really need to talk about it you just come in and say I need to see my counsellor. So you don't have to carry the feelings around, you can just come out and say it. Everything is put down and gets sorted out (Alison).

The relapse prevention group also provides a lot of practical peer advice dealing with specific vulnerable situations; for example christenings and funerals; or personal moments, for example dealing with cravings, agitation and anger; or people, drug-using partners or friends.

> Like I've often been here and said I feel just that I'm ready to get out of here and just go and get stoned you know that kind of way, just feel that I can't cope and they kind of help you or they make a little plan. They kind of do out a little bit of a plan at the weekend so you have somewhere to go or somebody to see so it will kind of keep you

going, that you're not going to be sitting around idle and you might be thinking and doing something (Fiona)

The relapse prevention helps to reassure participants that they are dealing with similar situations, that they have common cause in being together. It helps to provide a focus for the overall programme in the sense that it provides a clearer meaning for groupwork, as distinct to individual counselling or learning / groups.

…everybody who is here for rehabilitation wants the groups so that they can deal with their stuff (Fiona).

You learn off the group of people itself..Just say you go into a session and your listening to stories, you can relate to all them stories and when I relate to all them stories its like well fuck it I'm not the only one that done that, they done that as well and they're after getting out of that and they're not wrapped up in the guilt and I'd say well why am I wrapped up in guilt. Then I'd go to someone else and we'd do another session on…whatever it is or else I'd talk to a key worker or a counsellor, Well why do I now feel that and they'd say because your not letting yourself feel that, because your after putting this in front of you, well this is why your feeling this….and then your learning right, so that's what that feeling is for and then there's a lot of things around what makes you think of drugs, why is it there and like the wheel of change. You know learning all these type of things, more psychology all of that but they draw it out instead of words - in our language (Pamela).

Someone would come out with something, a problem…. Say I'd come out with something and other people who have gone through that are saying well this happened to me. I never noticed that really before and there's a genuine, although there was genuine willingness to help but this group really is a very special group, there's something in it, a definite kind of honesty to help each other with…..I found before people would help you but they'd help you for their own gain and remind you that they'd helped you. Very supportive group definitely (Tony).

Lately at the groups I haven't had too much to say and it does be just, other people. Sometimes its kind of a bit kind of reassuring when you hear of what other people are saying and you realise you re not the only person. Especially when I came up first I felt Jesus Christ, you always do think you're the only one. But until you come to things like this or an NA meetings and stuff you always go out feeling Jesus and I suppose its very selfish kind of to think like that, that you 're glad that there's actually other people in the same situation (Shane).

Groups often tend to be quite tense at times and it is evident that members find it as difficult to listen to others' accounts of their progress as to account for their own progress. Furthermore, there is a fear that group discussions could actually precipitate relapse, and a desire for more group direction in such situations.

Some bring in a shopping list of things. That is what they are only short of doing……Sometimes it's a pain in the ass. But I have to say it's a great place as well. For every bad thing there are two good things about it …the fellow was going on about what you feel when its going into your arm, here I am I just want to go out and get one. It was so much detail. And it took me, a participant to say look I think you are going too far

now. That is what I hate, they let people ramble. They take over the whole class with one person. And everybody is there to learn, not just from her or him (Niamh).

> …Its very good yeah but as I said one day, I said the only thing about doing it on a Friday is your going out with that in your head. I know its relapse prevention and all but its drugs, drugs, drugs your talking about through that class, you know that kind of way and once or twice it has put a goo on me kind of thing, to say yeah well I wouldn't mind a bit of that today (Shane).

Despite its tension, the relapse prevention group is regarded as one of the most important components of the programme. In particular, participants appreciate the group's pragmatism and realism in that it accepts that relapse happens and that occasional use of drugs might not constitute a major problem for any particular individual.

> ….you don't be condemned or anything for it, its part of rehabilitation is to relapse and they accept that, they actually accept it better when you own it and you do say it and admit to it and your able to say how your feeling about it (Fiona)

> There are people that have a joint once a year. And you wouldn't call that a problem. It's just if it's a problem…..It's basically the cause of the problem. It brings up all the feelings of anything like that. With me, it's any kind of drugs because I wouldn't have stopped at having it once. So that would be a relapse for me. I drink the odd time but I wouldn't call that a relapse. I am not doing it to forget about problems. So it's why you are doing it (Alison).

Keyworker

In addition to groupwork each participant on the programme is assigned a keyworker who meets participants once per week. These meetings usually take place during coffee break time or at 2 o'clock after other participants have left. The focus here is on a general discussion of attendance: How they are getting on? How are things at home? Or, how are they getting on with other participants?

> A key worker you go to just if you need time out or just basically if you have a bit of a problem with a member of the participants or a member of staff or whatever you'd mention it to the key worker, what they recommend is that if you've a problem with somebody that you approach them yourself first and if it carries on then you bring it out (Shane).

Child care issues come up a lot as do other practical welfare matters.

> She sits with you and chats to you. Or if am trying to get *(child)* into a crèche she will help me with all that. Things like that. If I really need help she is available. And she is so down to earth; you wouldn't feel bad talking to her (Jennifer).

Sometimes there is a discussion of relapse prevention, but usually from a practical perspective. Problems in relation to any single participant's participation in the programme

are also discussed in keyworker sessions. A standard labour relations procedure tends to be adopted for dealing with such problems, although, as already mentioned, staff do not describe CE as a form of work.

> There are rules and guidelines here and if they don't adhere to these the co-worker talks to person concerned. They are made to feel responsible and this helps to empower them (staff member).

The focus of these procedures is usually on attendance: a participant may be asked to sort this out within four weeks (verbal warning) and if nothing happens they would be given a further four weeks (written warning). If nothing happened at this stage they would be let go off the programme.

Alongside the keyworker system two project staff (manager and senior project worker) provide optional counselling sessions (4 currently opting for this). The overall counselling model is non-directive and motivational, giving participants space to speak and engage in personal reflections. Counselling sessions are also an alternative to group sessions for dealing personally with relapse prevention issues.

> I think I am still dealing with things, still dealing with issues that hurt me so I shouldn't have to say it in a group. And have people judging me. I don't think its right. They have to give you space and time to talk when you want to talk or need to talk then you can do it in a group (Margaret).

Counselling sessions are reviewed on a six-session basis. Counselling is supervised through external mechanisms, paid for directly by counsellors. Counselling details are not shared directly with team.

Staff routines

Alongside groupwork, keywork and counselling counselling, staff also spends a lot of time in planning and processing their interventions. Staff assemble in the project between 9 o'clock and 9.30am and prior to participants' arrival there is a morning staff meeting which is initiated by one of the keyworkers, each of whom are assigned as a day duty worker on a rotation basis: Day duty worker initiates next day's meeting and this commences with sharing practical information on messages that have come in and that need to be followed, along with the assignment of practical daily tasks and use of rooms. Generally, the discussion is not focused on participants and their progress but rather is concerned with routine, day-to-day management issues.

Similarly, after lunchtime, staff has semi-formal discussions on the progress of the programme and of individual participants. This mechanism facilitates decisions on whether particular issues need to be followed up with any particular person either in groupwork or keywork. Alongside these informal discussion there is also a formal team meeting each week. The focus of this team meeting is the project's general development: timetables, external inputs, planning / reviewing residentials or other special activities. The focus is not on

specific participants except in exceptional instances, where a participant might be applying for an extension (rollover) of their time on the programme.

In addition to staff meetings afternoons are used by staff for dealing with paper work and for participating in supervisory sessions. The senior project worker provides individual supervision to three other workers once per fortnight and the manager supervises him in turn. The focus of supervision is on individual progress in relation to input onto the programme. Workers have an opportunity to discuss individual participants if they wish to. The three participant workers also receive group supervision from an external consultant.

There is no clinical monitoring of participants on the programme by way of urine testing. If participants present in morning time with outward symptoms of intoxication this would be discussed with them aside in order to ascertain whether they should be asked to go home and rest. However, this is rare.

Overall monitoring is undertaken through assessing:
- attendance
- level of interest
- participation in groups
- willingness to get involved
- self-esteem and presentation
- dealing with external behaviours as appropriate
- openness

Furthermore, participants are expected to pull together around individual group members who may not be doing well. As already mentioned feedback to participants on monitoring is provided through keyworkers.

The programme is offered to participants for a 12-month period. If participants wish to have an extension of the programme they may apply in writing setting out the reasons (e.g. intention to organise a detoxification programme, intention to take up an educational course, intention to secure housing, etc.) This letter of application is addressed to management committee. In practice staff, following a consideration of participant's participation and progress in the programme takes the decision. (The practice of offering a rollover was discontinued in December 2001).

Conclusion

Sections 1 and 2 of this report highlight the wider policy, social and community dimensions to drug problems, particularly as these are experienced in estates such as West Tallaght. These contexts help provide an understanding of TRP, as a community-based intervention for drug users. However, once set up TRP needed to move beyond this social understanding into a more directly effective relationship with persons – problem drug users – who were centre stage to the problems being experienced. The participant profile in Section 2 provides some insight into the fragile nature of this endeavour and helps explain the way in which TRP

sought to develop its programme gradually and with sensitivity towards the views and circumstances of its participants. As mentioned previously a programme such as this will hardly be able to respond comprehensively to its likely community demands: it therefore needs to proceed with prudence. In making its selections about programme elements TRP drew greatly from abstinence-models, particularly in relation to developing a daily structure, having an educational input, and through engaging participants in a number of group processes. Also in terms of providing a safe, secure nurturing environment for programme participants, TRP was influenced by traditional abstinence programmes. Initially, project personnel would have seen the achievement of abstinence as a programme goal and this indeed would have helped in its early structuring of the programme. However, as the programme progressed it became clear that this particular objective was of less importance that that of trying to improve participants' management of their daily lives, a progression that was influenced greatly by participants' own contributions to reflecting on programme progress and development. In one particular area in particular the programme has made great strides: it has developed a practical approach to relapse prevention, in particular emphasising the importance of individually tailored assessments of risk and of measures for avoiding problematic drug-use. The programme has a finely tuned system of communication between staff members and a workable system for providing keywork support. Overall, it is clear that the project has overcome the practical task of forming and developing a programme that is coherent and remains consistent with the vision that gave rise to its founding.

SECTION 5:
PARTICIPANTS' PROGRESS AND OUTCOMES

So far, in this report, the following have been considered. First, the changing social and policy context, surrounding and contributing to drug problems has been analysed. Second, the emergence of TRP, as a community-based and community-managed therapeutic programme for drug addiction has been examined. Third, the profiles of prospective participants onto the programme are assessed, within the overall context of referral, assessment and induction procedures. Some attention is given to differential profiles between those considered successful or not on the programme. Fourth, the report explores the way in which TRP has focused on the underlying causes of addiction and personal change in prevention and management of relapse as its core objectives. The key elements, routines and structure of the programme that has developed are also described. There is a need now to discuss outcomes, or the success or not of the programme in achieving the desired changes among programme participants. Clearly, the project's own system and procedures for referral, intake and monitoring provide a basis for making this assessment and, as already reported, the project has made a judgement between successful and non-successful participants. In the context of this report however an overview of outcomes needs to be corroborated through an analysis of separate, independently collected data. Also, an understanding of outcome needs to be specified.

Clearly, the desired outcomes in a project such as this are linked to stated aims and some mechanisms for assessing their attainment. TRP advocates drug abstinence as an aim, although as already explained, this aim has been modified and changed as the project developed. This is fortunate perhaps, as drug abstinence is an extremely difficult aim to assess. Indeed, it can only really be assessed over a person's remaining life, whatever that may be. As already mentioned, longitudinal research on drug treatment indicates a high level of relapse, even among persons with a long record of abstinence. Thus persons who leave a drug programme in a state of drug abstinence and, say, maintain this state for a period of years, could conceivably relapse, at a future, unknown date.

Such problems are not confined to drug abstinence programmes. Similar difficulties arise in programmes that emphasise public health or harm-reduction aims. Outcomes in relation to these programmes may be assessed in terms of whether or not they reduce drug-related crime and illness. As with abstinence programmes such assessments can only really be made over a lifetime, post-treatment. Generally, whether treatment aims are focused on abstinence or harm-reduction, assessments of outcome tend to be considered within the context of drug-related behavioural changes that are quantified and aggregated. In this context therefore, the most informative assessments will be based on using standardised instruments with random sampling techniques across large databases. Clearly, given its size, the opportunity to apply this approach does not arise within the TRP and other; alternative methods of data collection and analysis need to be used.

As should be evident from the discussion in previous sections TRP operates from within an overall public health, harm-reduction model. Its aims and desired outcomes are focused on

achieving personal change. Its greater emphasis on cognitive rather than behavioural change reflects the project's aim to tackle the underlying causes of addiction and problem drug use. TRP is clearly not so much concerned with bringing about positive behavioural changes as helping to sustain changes that are already achieved and focusing on other forms of personal change. This is a core aim of the project: it is seeking to address participants' underlying personal problems and addiction and the way in which they have become reliant on drugs in dealing with these problems. Through getting in touch with these personal issues it is hoped participants improve their ability to better manage or avoid relapsing into problematic drug use.

Prospective participants are, in the main, already on methadone programmes and are likely to have already improved their health outcomes and prospects and are also likely to have reduced criminality and other drug-related behaviour. Indeed, entry onto TRP is conditional on an assessment of stability that assumes considerable behavioural change relating to drug use and criminality has already been achieved. It would be superfluous therefore to try and quantify changes in these behaviours during and after the programme as indicators of successful outcome. It would be impossible to ascertain whether positive measures of behavioural change could be attributed to the programme. They could indeed be attributed to other programmes or just simply might have happened anyway. And, as already indicated, the overall referral numbers onto TRP are too small for any in-depth quantitative analysis. Furthermore, the project's aims do not lend themselves to statements of intent or quantitative measurements in the way that behavioural changes might do. Because of this, this report eschews the use of standardised measurements of change in trying to ascertain and assess programme outcomes. Rather a qualitative approach is adopted in order to explore participants' perspectives on programme outcomes. Thus, in the paragraphs below, participants' insight into the process of change and the actual changes that have taken place. is provided, alongside their assessment about the programme's content, benefits, strengths and weaknesses. Taken together this body of data provides an opportunity to appraise overall outcomes.

As stated previously data was collected on current participants at two time periods. This permits an examination of how individuals were progressing through the programme. As programme entry is staggered, all programme participants were at different stages of programme completion. It is apparent from data analysis that as participants progressed in the programme, they move through different stages and this progression has an effect on how they themselves conceptualise personal aims, which in turn influences their assessment of outcome. The various stages of progress and assessments are now discussed under separate headings below.

Identifying with addiction

All of the female participants had problems identifying with being a 'drug addict'. The majority said that when they started on the programme they did not believe that they were 'addicts', nonetheless, they had all sought treatment in a drug service. Some of the women believed that they were not 'addicts' because their primary drug was methadone, not heroin. Others felt that they were not addicts because their drug using careers were relatively short, or because they did not use as much as their partner. In addition, as stated previously all the women interviewed were mothers, who (with the exception of one) had reduced or ceased using drugs during the course of their pregnancy. Therefore, the women frequently spoke of being able to control their drug use, and could stop using whenever they wanted. In the case of two of the women their drug use was very hidden, in that nobody, except their partners, knew about it, which may have made it harder for them to accept.

It is worth noting that although it was a gendered view, in that it was unique to the women, the female participants did not have a problem accepting or labelling the other female participants as 'addicts'.

> Like I have to say I had an awful problem when I came here admitting I was an addict. And I didn't see myself as an addict like. I just thought that I had made a mistake ……I never had used needles, I never robbed so I didn't see myself as being a junkie as such. So when I came here, I think I gave that vibe off to other people and I think they thought that I thought I was better than them. And, looking back, I did give it loads – "I never robbed, I never did this" and people used to say to me – you were lucky, you worked. And I said "yea I fuckin made sure I worked, you could have got a job". And they were saying – no, so I kind of used to have a bit of conflict with people over that. But then I realised after a couple of months that I was the same as them, no matter what we all had an addiction and that was it and I wasn't any better than them. That took me a while to come to terms with that. (Michelle)

> I thought I was doing grand but I wasn't accepting that I was an addict, I thought the minute I'd be detoxed and finished that's it I'll never even think about it again, you know that kind of way. I had that kind of way of thinking in my head but I was wrong! I had to look at all of that and it was like starting all over, it was like as if the first 6 months just went like that because I wasn't, I was thinking I'm doing grand. I was just concentrating on not relapsing, just don't touch it, don't touch it, don't touch it and don't be in this area or don't do this but it wasn't that issue at all. And when the penny dropped kind of and I was kind of God ah and it was real hard to swallow. Even still sometimes I hate that part of me, that its always going to be there and I'd be thinking, "God I've to bring up children now" and its like a defect or something but then I do kind of just think "well its only a small part of me as well". (Fiona)

> When I first came in here I was still very much in denial. No I'm not an addict, I'm not strung out, I can get off if I want to because I was only after getting off it on the baby and [*Name*] was only a few months old then, and I'm just on it for a while and then I get back off it but it was just me. I'm not an addict and that word alone, or a junkie, you know fuck off I can stop when I want to. But when I got in here I was always, I was

participating in every session, I loved it but I was still saying I'm not like them, I haven't got this problem but yet I knew I had this problem and the sad thing about it is it took me 6 months before the penny dropped…….. And when it did click in after doing counselling and then other things coming up in the class …..and I'm raging now that it didn't click sooner than that. I'm after wasting 6 months and its only in the last month that I'm really after getting into it and in that month I'm after seeing change in myself, the kids (Pamela)

Typically the women seemed to spend the initial 6 months of the programme coming to terms with their drug use and accepting their 'addiction' and dependency. This was something that the women appeared to regret, as they often saw this as wasting valuable time on the programme, rather than seeing this period as part of the therapeutic process. This is perhaps unfortunate that the women viewed the early stages in this way, as it is clear that they became very self-aware through this process.

Male respondents did not have the same problem as their female counterparts accepting their 'addiction', and it was not uncommon for male participants to refer to themselves as 'addicts'.

Cos when I came in here I though it was like, us against them, kind of thing! Us addicts against the staff, but it didn't turn out like that! Yea know eh, it was amazing like, for the first few months when I was being challenged by other members of the group I was saying these are meant to be on my side like! Yea know, what are you fucking challenging me for [laughing], or fuck this man yea know. But that's the part, that a good part of it in a way yea know. (Tony)

Acquiring knowledge and skill

Once participants began to accept their addiction, they begin to learn more about the nature of addiction and working closely with the group they start to identify issues in their lives. For many participants this was a difficult stage in the process. They acquired more insight into their situation and predicament and could no longer ignore or neglect the problem areas in their lives. As participants began to look at how improvements could be made they did so with the knowledge that such improvements would be difficult.

That's why I have often said to [Name], I've said, I don't know whether this place has made my trouble better or worse. Yea know, you start thinking about things sometimes and you get too defensive, yea know. (Shane)

Like, me kind of behaviour is a lot different. Like I know when I'm covering up something, big time, now, where as before I just laugh it off, or cry it off! It's always one or the other, it's either black or white, or up or down! There's no in between with me at all, I know that now! I suppose now that I know it. I know I have to change that, yea know that kind of way! I can't go back on it now, cos I know it's there! No matter, like at the first 6 months, and afterwards, they were all trying to tell me this like, and I just was not listening to them. It's only it hit me meself then one day kind of thing, with the help of them like, I don't deny that like! (Niamh)

Setting goals

With newly found insights into both addictions per se, and the participants own lives, comes identifiable shift in individual's treatment goals. The majority of individuals would have started the programme with the primary intention of coming off their methadone within the 12 months. Perhaps the main reason for this is that they saw it as something tangible. Methadone was a physical representation of their drug problem, of how things had gone wrong. By getting off methadone, perhaps they could then put things right. According as participants immersed in the programme however, their approach to methadone changed and their aims and priorities shifted. As other issues emerged, participants began to take responsibility for addressing problems in their lives, and initiating changes. Accordingly, abstinence from methadone ceased to be the sole goal of treatment.

> Well hopefully, at first when I came in here it was like I'm getting off methadone in a year and it was a big problem before, it was a horrible problem and I have to get off it fast. But now I'm after accepting right it will take me 5 years, 10 years. I'll wait. Instead of pushing myself and relapsing all the time! That's what it used to be but now I've accepted that right I can live a normal life and it will take me a couple of years, I'm grand and when I'm ready I'll come off it, instead of pressuring myself, I have to get off it because my kids are getting older and that's what it was with me. But now just to have a normal life, get out and get a job from 9 to 5 and get my kids sorted and just be happy, like I don't want much out of life, just for my kids to have a proper education and get a job and to be happy in life. That's all I want, no drugs or nothing in my life, no complications or anything like that and if my kids have anything to say that I'll be open there for them and I'll talk to them instead of pushing and hiding it and just face me problems instead of pushing them under the carpet all the time. (Pamela)

> Yea I am yea, but I don't know, I suppose like I just want to be off it really quick! And I did that and I went back on it again, like yea know, so, I'm just doing it slowly! I suppose in the next 6 months hopefully. Well that's what I hoping, but then again, as everyone says like, I'm fairly stable and all, and I'm only on 25 mls so like the way it is, if I do it, I'd rather do it slow, and get off it, than do it fast and end up back on it! I'm not going to put a time limit on it, cos I find I put myself under a lot of yea know, pressure, and all like, that's what I did before and then I'm killing meself cos I'm not off it yea know! So I'm not going to worry too much, the way it is it'll happen yea know. I'm not going to rush it so, I'll do it properly! (Michelle)

> …and I know the course has made me kind of, I don't know, buck up or something, I don't know what, its done something for me anyway! I know what I want and that's the main thing! At first when I came here it was I want to get clean, this that the other, yea know! Now it's not, I can see, that it's not just about drugs, yea know! I have problems with me family and with my siblings kind of so to speak! (Shane)

For some participants their new aims and priorities mean confronting, and dealing with major issues in their lives, such as relationships with family, partners, and children. The support provided by the programme staff and other participants is vital in assisting individual though such difficult times.

cos like I'm living with someone that's kind of, he's on methadone but he's on tables as well. Yea know, every so often he goes on binges and it's, ah its horrible. And I used to let him away with it like, and now I'm starting to realise that he's probably not ready to change and I know if I say with him I'll probably end up back down there! Like I've been getting a lot of help and support around that, which is good! (Jennifer)

ASSESSING OUTCOMES

Progress in reducing drug and alcohol use.

Although individual aims change and develop through the programme, participants generally maintain a sense of seeking to reduce drug and alcohol intake. Some participants, for instance, reduce their methadone dosage, over time. In addition, participants began to look at their substance use in a new way and identify what they saw as problem behaviour.

> I used to take, and they think I'm on 80mls, but I take 40, basically! Yea know its there, kind of as well, but I do help a friend of mine as well; she's after getting kicked off her clinic. So they don't know that! So I take 40 and give her the 40 as well! (Niamh)

> Yeah so it's a stupid bleeding thing really and then even with the methadone I get up and there's a lot of times I get up and take it and I'm saying I fucking hate this stuff. I hate having to depend on this but still I say all that and I'm saying it while I'm drinking it but that's something that I really have to have at the moment. I have to have that at the moment. The first 2 things on my list is the alcohol and the benzo addiction, I have to kick them because I mean being sick from benzodiazepines is probably worse than being sick from heroine and methadone or whatever. I went through it before and Jesus its horrible, its absolutely horrible, you just think your going totally, totally insane…. That's what I thought and the reason I ended up going back on them was because I got a couple off a bloke one day just to see was I going insane or was it a sickness and I was grand after I took the couple. Jesus I was doing awful, I was smashing the stereo up and all because I couldn't find a pair of jeans one morning. I was really really. And then I was talking to a fella afterwards and he said he went through the exact same thing. He really, really thought that that was it, that he was losing it, it's horrible, absolutely horrible. (Shane)

Two of the participants specifically mentioned the fact that they considered their alcohol consumption to be a problem. The majority of respondents said that they were social drinkers. In the case of one of the participants, he had managed to successfully to reduce his daily alcohol intake since starting on the programme, but in the course of both interviews he made numerous references to his drinking and the fact that he wanted to stop drinking at home completely.

> ...I'm drinking probably two, three cans now in the evening! Still! It's still a big problem in me life at the moment, but yea know, with time. And before I started here I was drinking about a naggen of Southern Comfort and about 6 cans a night so, what's two cans? That's the way I look at it, but then I think, I don't go out really on the weekends,

cos I know if I go into the pub I'll just fall out of the pub kind of thing, yea know! So, I don't like, I hate being like that, so I just eh, the way I do see it like, I say well other people then that go to the pub they drink the same amount I drink yea know, during the week. So! I don't know if that's a good or a bad way of looking at it like yea know! Some people down a lot of pints on the weekend ….I feel that I'm tackling it anyway, kind of thing! I'm able to put up a bit of a scrap against it kind of thing, yea know! I'm slightly getting the better of it, I think yea know! (Shane)

Regarding the second participant, between the first and second interviews, she had begun to drink to a degree she considered problematic, and having identified this as a problem, she had stopped drinking alcohol altogether.

> ….I've given up drinking like. I wasn't always like into the drink but when a friend of mine died and I started to yea know, from the funeral yea know going out to the pub kind of. And for about two months I was just, or even more it could have been, I was just drinking every day at home. But eh, yea with the relapse here and all like, I was saying shite and so I've stopped now, yea….It was really bad cos it would have been like fucking two fucking addictions (Jennifer)

While there was no dramatic reduction in participants' methadone intake, participants did say that their attitudes towards drugs had changed as a result of being on the programme.

> …..up here has definitely changed my whole mindset on drugs because I've seen how it destroyed people, destroyed families and when you hearing the stories from someone that's sitting across the room from you, it really fucking hits home to you …how fucking horrible it is. I wouldn't see any, although I would probably around hash. I wouldn't see hash as, as dangerous as other drugs but I still wouldn't advocate it to anybody…. and I would have been a big supporter to legalised it. Now I don't think they should actually, cos it might create more problems. No my attitude has turned full circle on drugs definitely, and it has a lot to do with TRP and relapse prevention and looking at drugs and just looking at the world really I suppose as well. (Tony)

> I have changed my views on drugs and before I used to think a few drinks and a bit of hash won't bother anybody. It was okay. Through my pregnancy I was just waiting to have the baby to get back on it. And I realised I couldn't do that because of how bad I did get. And how out of control, you can't keep control on it. (Alison)

Lifestyle developments

Participants' involvement in TRP has had a positive impact on their lifestyles. Daily attendance at the programme gave them more routine and structure in their lives. Participants said that they were eating regularly some reported that they had or were trying to give up smoking, and generally many said that they were much healthier then before they came onto the programme. The only complaint for some was that as a result of their improved diet they had put on weight.

> Being here has changed my attitudes and behaviours a lot toward everything, even about being able to sit in my own company and relax in my own company without a television on. You know all of this, completely different ways, or when you're hungry, kind of wait

and do something to eat properly rather than running and grabbing a bar of chocolate, things like that. It's just getting away from the whole instant hit and trying to change your life completely around and from the start I have to say even in the learning classes, relapse and prevention and all, I was applying them at home, I was trying to say well I'm only here till 2 o'clock so I've the whole rest of the day, I'm not going to just switch back to being old [name] at home, when I understand what they're saying here I'm going to try so that kind of worked for me, even with [child] instead of just giving him something quick or grabbing something out of the chipper I'd wait and I'd do something because I don't want him getting used to just grabbing what he wants straight away and getting it. So even in little things, trying to apply them at home, from the start I was doing that now you know, so. (Fiona)

I never used to eat 3 meals a day, I do now. But it's your system that tells you that you are not taking in certain things that your body doesn't need. I never thought about that before. I would just eat here and there before. And little things I would have before, like chocolate and ice cream. (Jennifer)

When I first came here I was attending Tallaght Hospital, with me weight and me blood and all that. Eh, now it's kind of, I went thought all the tests and everything to see what was wrong, and they couldn't find anything, and everyone kept saying to me it's cos your so stressed out and all like! And I was not ….Everything is kind of grand now! (Alision)

Personal Development

Participants also reported that as a result of being on the programme they had become more self-aware. Through the group work and the counselling, participants get a unique opportunity to look at themselves, and the impact they have on the world around them. As outlined previously, particularly for the female participants, part of this process was actually accepting that while they were a 'drug addict' that this does not define them as a person.

As regards meself I've definitely got more self-awareness and stuff like that, yea know, over the last few months! Like I look at meself more than I used to kind of thing. Yea know that kind of way! I don't mean look in the mirror [laughing] I mean, yea know looking at me problems more and more! You start to kind of, I suppose you don't look at them, how to fix them!…………And I've come down a bit on the methadone. It s been a long time since I've come down on anything! (Shane)

Well I don't know, you see all of that [going into the chemist to get methadone] was a big issue for me because I was so ashamed of that part of me but I was denying that part of me. I wasn't owning it and just dealing with it. I was denying it completely. I thought no I'm grand and it wasn't that, I wouldn't think that I was any better than anybody else, just for me it wasn't good enough for me. So my expectations would be always up through the roof do you know that kind of way but when I started being more realistic and kind of saying well it is me but its not all of me and I'll have to accept this part even though I don't really like it and do you know what I mean, its after making me a better person. (Fiona)

And like I've got better at talking and all because for a while they were saying like, your too quiet, your not vocal enough, and I was a bit freaked over that like. I was saying can

no one be quiet and yea know! And they were, like [*Name*] was, explaining it to me then, and its just like, she was saying, if you have got issues and you are important and we'd like to hear what you want to say as well! She said sometimes we can see you're going to say something, and then you just kind of back down…..I'm really getting loads from it, and sometimes you don't realise now much you are getting until like, they bring you in and sit you down and say it to you, yea know. Cos they feedback to you, which is a good thing as well, every so often! They'll come in and say what you're either doing good or if your not doing something, and why aren't you working, yea know, things like that! (Jennifer)

As a result of increased self-awareness and self acceptance, participants also spoke about how they had become much more confident in themselves and in their ability to deal with situation.

Like everything about my life has changed, yea know like! Old friends, and all like, everything had changes. When I started here like, I planned on, yea know, the only think I wanted to do really when I came here was to build up confidence, yea know. And like I was still being with me friends and all that yea know. And nothing was changing, yea know, but then like, it would be pointed out to me, well you can't change this part of your life if you don't change that part yea know! I kind of just broke away from everything and just worked on myself and left everything! (Alison).

Yea, and it does build your confidence, yea know to go into places, and not say God I can't do this! I used to do that a lot, but now I'm probably like, I'm not as afraid to do things, yea know, so it does help you in that way, yea know……..do thing like going to the cinema now, or I go to the library with [*Name*] at weekends…. And walking as well, which is good cos I've always wanted to kind of do stuff like that, but I don't know what used to stop me. I think, I was scared people would think I was stupid. And I'd go out on my own now, yea now, to a library or somewhere like that yea know! (Jennifer)

…..even the baby's Dad I was having a terrible time with him. Even though it was finished but he was still there. And I hadn't got the heart to say it to him, look you are not seeing that kid any more. You are causing too much problems. I kept putting myself through it every time he knocked on the door. I was feeling sorry for him. All things like that. Now he wouldn't come near me. Its because I am here. I don't want nothing to do with that any more and he is not having anything to do with *(child)*. (Alison)

For many participants being on the programme had a positive impact on their relationship with family members, partner and their children. For participants with non-drug using partners, being on the programme was seen as an important step towards recovery. As most of the participants were parents, many spoke about how the programme in general, and the parenting course in particular, had helped to improve the way they deal with their children. Respondents also spoke about how they used the skills obtained in this course to deal more effectively with their parents.

I know she's *(partner)* got more trust, and she feels more comfortable about going over to her Da's or wherever, and I'm not going to be scagging off and stuff like that yea know! She's definitely happier anyways I know that! And I'm glad; because she hasn't been happy, and I'm surprised she stuck with me to be honest with yea know. She hasn't been happy for the last few years, I didn't know it, yea know, but I know it now, kink of

thing! Which is another thing I'm seeing, yea know that kind of way, I just thought everything was grand, surfing along, taking me methadone, I'm grand, I'm not taking any gear, yea know! (Shane)

They [parents] could see I was making a genuine effort, they could see I wanted to change, my father was all for it, my mam was a bit sceptical and is still kind of sceptical, not of me, around the course …..the way my parents would look at it is if your doing something for yourself, your obviously making the effort no matter if you're on TRP or if you're on with a doctor or whatever. They would appreciate that so it definitely has helped and it has helped me, definitely. Tony)

 ……I suppose like when I first started here, even when I got pregnant, yea know, I kind of depended on me family all the time and like they got used to it as well! And now like they see me moving on, yea know, and they're not yea know; so it's kind of a battle yea know! For so long I depended on them to do everything! (Alison)

I think it's [relationship with son] has got better though, do yea know, cos at the start like, I don't know, I was kind of afraid of being a mother, do yea know that kind of way like! Like I love him with all me heart and soul, but I was terrified of doing the wrong thing, yea know, but like now it's grand like! It's kind of like he's plodding along with me, yea know! (Alison)

Further education

Four of the programme participants enrolled in the Addiction Studies Course in Tallaght Institute of Technology. One of the participants left to have a baby and another left the course after approximately 3 months but intends to return at a later date.

I started it but I left it, it was getting too much yea know, cos I was doing the aftercare, and like I don't know, I just felt as if I was starting too much, and me Ma had to mind the baby all the time, yea know! And like I was only getting to spend half an hour with him..(Alison)

At the time of the follow-up interviews two participants were completing their final assignment for the addiction studies course. The participants spoke favourably about the course, despite the fact that on occasion they considered it very basic, as it covered material that they were familiar with though both their own personal experience, and lectures in TRP. Completing the course not only provides the participants with a qualification, but also brought them into close contact with non-drug users. One of the participants eventually told the others on the course of her drug using history, and considering the shame that women often feel about their drug use, this was an impressive and brave decision.

they nearly died, they didn't have a clue …. I thought they'd know or something! Like I knew a good few thing like, yea know! Yea know, like what yea need for a turn-on and all this, but they hadn't got a clue! And I was kind of, did none of yea suspect! ….But it was really weird like, I was kind of sitting there like, going ah, I'm going to tell them now like, but it was grand then. I thought, I really did not, cos they're an awful lot older than me, they're all like, probably like mothers and yea know, there's a Ban Garda down there, there's nurses, all kind of, there's an army bloke! I though they were going to treat

me like, ah she's an addict now. I really did, I thought I'd be treated a bit different! They were very nice now like! I think I really trusted them after the weekend;….I got a bit of a kick out of it, ha none of yeas knew! (Niamh)

Practical issues

Participants frequently mentioned changes that were happening in their lives, that were often viewed by themselves as being unremarkable, but which indicated important positive outcomes. For example, one participant who was living in her family home and had been on the housing list for a number of years was actively pursuing the council to get housed.

> ….I have a meeting at half two, and I wrote a letter, that I'm going to give them explaining like, that I'm not a bit happy, …so eh, I rang them the other day…like my niece stays the weekend and so does me brothers girlfriend…I'm on the list for 4 years now, four and a half years! I know there are some people on it seven years, what ever, yea know what I mean! But they know, I got a letter, my young one had meningitis, God love her, I got letters for that, I got a letter saying I'm depressed to bits - yea know what I mean, I need to get me own place! Things like that! (Margaret)

Many respondents had during their time on the programme worked closely with their key worker around various issued in their lives.

> …Its only now that I'm dealing with issues now with my son, that's why he's so angry and that's a big thing for me and *[Name]* and he's going into this project, through here, its to do with children if they've any family, brothers or sisters on drugs, its like one to one on them, its to do with Barnardo's, its out 3 years. I never knew anything like this till I came here that there's help but saying that I would never ask for help until I came here, I would have never known where to go, it was always no I'm perfect, we're grand, my kids is alright even though I know there was problems with my eldest child, why is he so angry, why is he so aggressive, he's not like [name] and then I started coming here and that's when I started saying right this is wrong with my child, opening up to them. They says right we can do this, how can we do that…..(Pamela)

Providing a critique

As is evident from many of the comments in this report above, programme participants are generally quite positive about the programme. In particular they appreciate the programme's role in assisting them to 'return to normality' or in reaching an understanding of what they need to do in order to overcome their vulnerability or susceptibility to drug problems. As already mentioned some participants have commenced addiction studies courses as a way of helping further with their understanding of drug problems and also as a way of getting out, getting into a socialising frame of mind and of "being around positive people". They openly acknowledge the important role of the staff in helping bringing these changes about.

> They were really there for you and they made you feel they would be there no matter what. They would go out of their way to help you. I thought that was brilliant. Usually

they are going its just addicts, or just kids, but they didn't look on you as any different to them. They made it nice. You were comfortable (Alison).

All the staff is great, they have great support for you. They will support you in anything you want (Margaret).

Its definitely a team, even around just complementing you, you know your doing great, just there'd be certain members like *(Name)* would do a lot. *(Name)* would just compliment you and its just nice to hear, you're a great person or just silly little things like that and they're more personal like. And, the likes of *(Name)* for instance would help you out too, say around money that your meant to get off dole or anything. *(Name)* would tell you what your entitled to and stuff like that so they're very supportive, very open and very helpful. Of course you can't get on with them all but I do, I would have reservations about 1 or 2 of them, you can't really like everybody but when I think about it I do like all the staff members, I do, I wouldn't have a problem with any of them (Tony).

Participants have mixed views about the programme's activity components.

.. the stuff that they do here is very basic, like it doesn't cater for everybody. Like the NCVA and all, I've passed all of that and your kind of sitting there and your bored….. I know other people that probably wouldn't have gone as far or whatever that they'd be interested in that and all. I've no problem with them doing it but I just feel…. if there was an option that we could come out and even have a bit out and do a bit of writing or something like that. I like writing or whatever else just that you don't have to participate in every single thing (Fiona).

We were doing the driving license for the computers. That was good but I am not really into computers. But its good to relax and work on them. But it depends on how I am feeling. If I am feeling any way bad in myself everything switches off. But if I am feeling okay I like everything about it. I know its to my advantage and if there is something going on there is someone going to be there (Alison).

Some of it is good. Drama, I don't think that relates to you being a drug addict. What good is that when you are dealing with addiction? What does drama do for you? I know it brings you out of yourself and makes you more confident. But I don't think we need that. Computers are good. It keeps your mind stable on what you want. So that is good. But the likes of drama and what we are doing now I wouldn't be into (Margaret).

Most days it's grand. But there are some classes that you get quite bored in. Like communications…. they give you parenting skills as well. You can use them at home. I got a lot….. It was really good. I have learned a good few things that I will use (Jennifer).

Last week we'd a homophobic workshop, 2 gay lads in and very interesting, very funny, gas they were. We done money management course that was excellent. We done a course around politics which would interest me. I would be interested in that, it was more around social issues and using your right to vote and stuff like that and I remember when … a lot of people in the group were going ah Jesus but it turned out to be one of the best sessions out of the whole lot. People learned a lot of stuff, and we're trying to get them back out since that (Tony).

Counselling is generally regarded positively, although it is felt that this can depend, at times, on the counsellor. Those who have successfully availed of counselling argue that it should be more available within the programme.

> I think they should have that more, the whole objective of the project is to look at all your stuff and get through it and understand why and answer your questions that you have around it (Fiona).

> I think more work with your counsellor, more counselling that is the whole idea of getting into rehabilitation. For me the counselling is more important (Niamh).

Furthermore, there is a view that counselling sessions need to be more distinct and separate from overall programme and some concern was expressed that returning to a group after counselling can be upsetting for both the person and other group members.

> I was all red and not feeling up to it. So I think they should bring you outside of here or do it after the hours. You can get a lot of people and they get real upset and they are coming into the group and their eyes are all red, and they can't focus in the group……And everyone is asking you are you all right….They have to understand we are a bunch of drug addicts, when you are drug addict you do things you don't want to do. You are not in your own mind. As well the relationship you have gained at home is a loss of respect and trust whatever. It's hard for us to come in and do this (Margaret).

> I am only getting into it after the half-hour. But you are rushed into drama, hello; drama isn't part of it. I am not going to go out and start acting (Niamh).

Alongside participant's positive comments about the programme, they also offer quite a lot of qualification and criticism. Generally, participants seem quite clear that the programme does not suit everybody who is on drugs.

> It does wonders for people, but I think it's who you are. It's not for everybody. I had my heart set on getting off drugs. So it's for me. I am going to work on myself. But for people who are still caught in the addiction it's not a good place to be. It just depends on the individual. It's like group work, not everybody is cut out for group work (Margaret).

> You'll have other people that I know that would be just into it for the experience kind of thing. I don't mean to get experience. I mean just to come up and see what its all about basically and they'll probably (leave) after a few weeks (Shane).

Other qualifications are generally quite coherent and similar comments tend to get made across the board. There is quite a lot of concern about the issue of confidentiality and this arises as much as a question as it does a criticism. Participants wonder the extent to which it is possible to preserve confidentiality given the programme's community base and groupwork structure.

> I didn't talk (in groups) for ages. I was kind of a bit closed up. I actually prefer more one to one than even talking in the group now. I don't give away a hell of a lot because

a few times things have gone back and I'd hear them outside. Because when people leave. Like confidentiality is grand when they're here for the 12 months but when they leave it doesn't stay with here, you hear things outside (Fiona).

They would have known each other in the extent they might have seen each other at the doctors or seen each other down scoring and definitely there is a lot of people, on the course who would be from the different areas. And they would kind of know each other, and know a bit about each other …. It's very hurtful to know that your opening up, saying something that you probably never said before and your wondering shit is this going to get outside the group or are they going to be talking about me. There was a stage when I wouldn't open my mouth because I felt very uncomfortable around certain members in the group (Tony).

This place is supposed to be a rehabilitation project. It is supposed to be people in recovery who are trying to get away from all that shit on the street. But they forget: at the end of the day, everybody here is still a drug addict. They are still going back out onto the street and I have heard back things I've said here in confidence as well. It's always being broke. Everyone will tell you that. Nearly everything you say here gets said back. I've heard back (Michelle).

Concerns about trust were also expressed in relation to the project's stated intentions of being inclusive and consultative and yet the need for members of the project staff to take charge and exercise authority as appropriate. In particular these concerns arose over a residential weekend organised by the project. Participants at the weekend were generally very pleased with the weekend and felt that it had helped them get to know each other more and also held them together as a group. However, they had a very strong sense of the weekend's ground rules being very firmly policed by project staff. For instance, there was deep concern that methadone supplies had to be held by staff over the weekend and given to participants on a daily basis. Participants also felt that staff tended to follow them on walks or stay up late just to make sure no drink or other drugs were taken. This experience made some participants feel that the way they were being treated did not necessarily match the rhetoric of inclusivity and participation.

Another example of feeling not trusted concerns an attendance rule that project participants should not have social contact in out-of-project hours. While some participants have no difficulty with this, others feel it shows a lack of understanding of the reality of trying to manage relapse, especially during evenings and weekends when staff would not normally be available. Other concerns are in relation to time-management on the programme itself or the manner in which staff might intervene in a breakfast or coffee break conversation.

There was some confusion among participants in relation to programme extensions. A number of participants were concerned that the criteria for awarding extensions were unclear and that furthermore that these decisions were taken, not by staff, but by higher management personnel, who had no familiarity, as they saw it, with programme development. Leaving the project at the end of twelve months is potentially, a very stressful time for participants and clearly uncertainty in relation to whether or not they will get an extension adds to their overall levels of anxiety.

I would say sometimes they don't feel they are ready but maybe they are. They are afraid of going back to sitting around the house and not doing anything and they might fall back into drugs.   If they haven't got something set up (Jennifer).

However, the data also indicates a worrying trend, the tendency for participants to shut down and cease to engage and participant in the programme, as their leaving date approaches. While in some respects this may be normal protective behaviour, in some cases this occurred mid way through the programme.

The way it is like, they pressure you into doing counselling and all that, yea know what I mean, so what's the point of doing counselling, if you're opening up a bleeding book and then they're after kicking you out, yea know what I mean, and it's left open! Things like that are left, and you want to try and forget about, yea know what I mean, so that's, now that's puts me off doing counselling. (Margaret)

I feel like I am growing, learning who I am. I still don't know exactly but I am getting more secure with myself. I still feel it will take another 2 years, I feel like closing up now, what am I going to get done now in the next 6 months, nothing really. So I feel like saying I can't do any more courses, close it now. By the time I get into it they will say your time is up and all that will be left. I know I could go straight back on the drugs. So it's the fear of that, I think the time is ridiculous. There shouldn't be a time limit. I know that people are waiting on the programme, but why aren't they out looking for people, there is such a long waiting list. That is the part I couldn't get over. They let people go who weren't ready to go. Yet they haven't got people to fill that place. I can understand people getting reliant on the course; there is nothing else there. I could walk away from here tomorrow and not bat an eyelid, I would fall down through the drugs, but in myself I am not committed to the place where it's my life or anything. I have to get on without it but the drugs part of it. I am not rehabilitated yet. There is a lot more work to be done. (Niamh)

Old resentments tend to emerge, and often in what appears to be anticipation of the inevitable hurt of leaving the programme, participants can become uncooperative, difficult and resentful.

………I was saying to myself, I'm not saying nothing in these groups like, anything I would say would be like in support of other people. I was very negative towards the staff, I'd be very rude in the groups, I mean I didn't care to be honest with you! I felt let down, I felt well I'm going to make it as hard for them in the last few months, as I feel it was for me in Ard Brachan that weekend. Eh, I didn't participate in groups, and yea know what I mean, I didn't, I felt like yea, that's the, I couldn't, I couldn't go on, what was the use of talking, what was the use in trying. I mean I thought I had done enough to get the rollover, and eh, I didn't yea know what I mean. (Tony)

That's what [*Name*] was saying to me today, I think you're going to finish with a negative kind of side to it, and it looks like you want to finish that way. And I says to *(staff member),* no I don't want to, but it's the way it's going to happen, because I'm dying to get out of the place now! And here *(staff member)* was looking at me, ah I thought all this was kind of coming up for you, at the end of your time, and I says I wish it was that *(staff member),* because at least I could put me finger on it and say well that's what me problem is here yea know! I said it's not that, I says to be honest with yea, I can't wait to get out! And *(staff member is)* looking at me, fuck like… didn't expect that

from me, not at all like! And … says it's just I thought you got a lot out of it, and I says I did at the start… I says, the rest of it's all false (?)……..there looking at me, yea know. Then… says, Jesus Christ where's all this coming from? I says look, you're after asking the truth, I says! *(Staff member)* said your probably having a bad day, I say I'm having a pissy day, I'm having a pissy month, actually I'm having a pissy fucking 3 months, I says. It seems you taking everybody and anybody on! Oh I think that's very unfair to be saying that about people! I says look *(staff member)* I'm not saying that about one individual, or two individuals! I says I think the way you are doing it is wrong. Your taking loads on together, and the group wont work! (Niamh)

Conclusion

It is unavoidable that a question asked of a programme such as TRP is: What were your outcomes? Clearly, this question cannot be answered without some attempt to define the particular outcomes that are desired. This is a difficult task. Drug users are idiosyncratic: they do not lend themselves easily to either a problem definition or a prescription for change. Further, while it may be possible to provide a broad overview of treatment outcomes based on a large dataset, this is hardly possible within the context of a small, community-based rehabilitation project. Moreover, in TRP it is clear that quite a lot of attention has been paid to individually customised programmes, although it is also clear that a lot more of this needs to be properly formalised through individual agreements with programme participants. In focusing on personal change the programme emphasises the need for participants to become self-aware: to recognise and understand the problems that they experience, to know when they have made changes and to learn from this as they move towards the next tasks. It is clear from qualitative data that programme participants articulate an understanding of stages of change and they also highlight particular issues they have addressed in seeking to deal with their problems. Participants express insight into what has changed for them and they attribute these changes to particular programme elements or staff interventions. It is clear that participants are generally positive about the programme and they recognise within it those aspects that have helped guide them through their individual processes of change. Alongside their more positive insights, participants also highlight some of the programmes weaknesses and consequently some of these have already been addressed within the programme.

SECTION 6:
SUMMARY OF MAIN THEMES AND RECOMMENDATIONS

In drawing together a summary of the main themes in this report it is important once again, to acknowledge the shortcomings of any exercise, such as this, that seeks to explore overall programme effectiveness. It is quite unusual for programmes of this type to be assessed or evaluated in randomised controlled conditions and clearly this is far from the case in relation to this review. No categorical claims of effectiveness can or will be offered. The discussion in previous sections above draws greatly from retrospective accounts and the review in design, structure and content, may be described as being more *formative* than *summative*. In this regard, the focus of this report is more on making sense of the TRP, of locating it within its varied contexts, of providing feedback in order to assist ongoing decision-making, than in seeking to pass definitive judgement on its achievements or efficacy. The discussion below needs to be understood within the parameters of these methodological qualifications.

The TRP is primarily concerned with providing a service to people who have problems arising from drug taking. These problems are fundamentally psychological in nature: drug taking is an individual act and it has individual effects and consequences. Ultimately, the value and efficacy of any service intervention is directly linked to its impact on the individuals concerned, in terms of assisting them to make, and manage, decisions with respect to their drug-taking. Clearly, this final section of the report needs to draw conclusions on these aspects of the project's functioning and this theme is returned to later below in our discussion of programme effects and outcomes.

Meanwhile, there is a need to summarise our understanding of drug taking as a public act one that is inextricably linked to multiple social and community contexts. It is important to understand the influence these contexts have on the direct delivery of services to the individuals concerned. It is particularly important to state that since the drug problem first escalated in Ireland in the late 1970s, it has been concentrated in urban neighbourhoods such as the one in which the TRP is located: neighbourhoods that are characterised by poverty and generalised deprivation. The drug problem has had a deeply troubling impact on these communities, over and above the totality of its effects on the individuals concerned. Furthermore, for most of the period since the problem first escalated the health and social policy response has been quite muted. Inasmuch as an official response existed, up until the early 1990s it drew mainly from a disease model of addiction, one that had major inherent limitations and, overall, lacked an appreciation or understanding of the deeply complex social and community dimensions to the problems being confronted. It is only in the last six years or so that there has been a substantial investment into localised services in worst affected communities, and the previous absence of a coherent official response may be perceived as exacerbating the predicament of the neighbourhoods concerned.

Recent improvements in resources for drug services may be seen as arising from two sets of demands. On the one hand, in the absence of evidence of coherent official responses, local

organisations in worst affected areas began to articulate their own understanding and response to the situations they confronted. This process of community engagement with the problem encompassed a variety of often contrasting actions. These gradually showed some convergence, underlined by a perspective suggesting that the treatment and rehabilitation of drug users is often best undertaken within their own communities and through the involvement of indigenous, locally-managed and structured organisations. Alongside this convergence, there has also emerged quite widespread community support for the provision of drug substitution programmes as an alternative to the more restrictive, drug abstinence programmes and inevitably community organisations have become directly involved in facilitating and managing the development of these programmes.

The second set of demands giving rise to an improvement in resources for drug services emerged from among health professionals and agencies with a public health commitment. Many of their concerns first found expression during the late 1980s as a result of the escalation of HIV and HCV infections among injecting drug users. The articulation of these concerns helped shape a re-appraisal of drug treatment objectives, leading to the introduction of harm reduction as a stated public policy aim. This re-shaping of policy reflects a growing international trend; itself highly influenced by a body of longitudinal research that advocates the need for multiple drug-treatment strategies. The idea of seeking drug abstinence from each individual episode of drug treatment has been replaced by a more sophisticated notion of individual drug users requiring several episodes of engagement with a drug treatment system, which itself operates through a number of drug *Service Elements*, depending on individual drug-user needs, and at different times in their drug use and recovery careers.

Arising from both community and public health demands a momentum towards funding and developing services for drug users gathered from the mid 1990s onwards. With new outreach services, addiction counselling and various medical services the health boards became engaged in developing both a local framework and a management / organisational structure for implementing a comprehensive service. The framework, which is still emerging, includes local drug task forces in designated worst affected communities, thus allowing for a coordinated response and the identification of service shortcomings. It is through this framework that a gap in provision of methadone maintenance programmes was identified and articulated. As a result, there has been an expansion in methadone maintenance programmes and in Tallaght alone there are now approximately 600 persons on such programmes, accounting for nearly 10% of the national total. The framework also facilitated the identification of a gap in provision of places for rehabilitation, a process that inevitably led to the founding of TRP.

In light of the above summary of contexts, it is clear that TRP did not emerge as a singular expression of a particular type of service need, in the way, that specialist residential services for instance often do. Rather, its emergence is inextricably linked with a number of social processes of change and development, happening at both local and wider policy levels. Its future therefore, is very much tied in with these wider processes, potentially in an arrangement that could allow it to help shape and influence the overall direction of change, a level of influence that ultimately is best exercised through documenting and communicating the project's own experiences. Clearly, if the future of TRP is to have consistency with its origins, it is one in which it must have an integrative role in drug service developments in

Tallaght, generally. The need to constantly seek and maintain such an integrative role is an imperative in the project's future development. In this regard it is important that the project continue to be represented on relevant coordinating structures with respect to drug problems in Tallaght, and specifically it should seek representation on the local drug task force. Furthermore, it is crucial that the project remain cognisant of the importance of other community and local service influences with respect to its own internal programme development and structures. This can be achieved in a number of ways, both in terms of how the project's management is structured and the everyday mechanisms for linking in with relevant community and other agencies, and these are discussed later, below. It can also be achieved through attention to how the project's mission with respect to rehabilitation is structured and articulated within the wider context of other policy and practice developments and especially in terms of being clear of the particular contribution TRP can make to the rehabilitative process.

At its outset the TRP adopted an approach to rehabilitation that underlined the overall importance of achieving a drug-free status by prospective project participants. In some respects this objective set the project apart from a number of other community agencies, which by necessity, had been instrumental in facilitating the development of badly needed methadone maintenance programmes. As TRP developed and adapted to the needs and circumstances of its participant group however, it evolved a rather more pragmatic approach to rehabilitation wherein the objective of achieving a drug-free state does not feature as a participation requirement: indeed, the achievement of a drug free state is neither over-stated nor monitored. Yet, in internal project discussions, the mission of TRP continues to be referred to in a manner that sets it apart from other services, in a manner indeed that sometimes suggests that unlike some other services, *it* is concerned with rehabilitation, the implication being that others may not be. While these discussions do not reflect conscious attempts by the project to accentuate such distinctions, the effect can nonetheless set the project apart from other services with the risk that treatment and rehabilitation are seen as separate and not complementary processes.

In reality, bearing in mind the emerging *ServiceElements* of service development as outlined in Section 2 above, virtually all services, including outreach and other low-threshold services, contribute to rehabilitation. They all provide interventions from which various packages or combinations help to stimulate and sustain problem drug users' engagement in rehabilitative processes, which can change and develop over time. Rehabilitation does not commence or end when drug users come onto or leave TRP's programme, or indeed any other programme, similarly defined. TRP is one of a number of broader programmes and services out there engaging with drug users during both different periods and at different points within any one period. It is a distinctive service, but its distinction is not that it is rehabilitative and others are not, but rather that it makes a particular contribution to the rehabilitative process, just as methadone maintenance does, or participation in counselling does, or that needle-exchange schemes might, and so forth. Indeed, treatment and rehabilitation in particular are perhaps best seen as integrated and not indivisible concepts. The challenge here is to identify and illustrate the distinctiveness of TRP within a unified treatment / rehabilitation model. It is important that this is done in a way that allows both prospective service users and other service providers to understand and appreciate the particular contribution that can be made by

TRP. It is also important that it be done in a manner that helps build the type of professional and working relationships that can sustain a more integrated service to drug users.

TRP is a community-based, therapeutic and educational day programme for drug users. It is a twelve-month programme with a daily attendance (Monday-Friday) of four hours. It is designed to suit drug users whose drug intake has stabilised and who indicate a willingness to engage in a process of self-examination and therapy leading to an improvement in their abilities to manage and prevent destabilisation or future problematic drug-use. Although TRP's therapeutic model places great emphasis on the importance of routine and structure, it is not concept-based or over-constrained by an idealist approach. Rather, it is eclectic with a flexibility that allows the application for a variety of techniques, as appropriate. It draws influences from the therapeutic structures of drug-free programmes, in the sense that addiction and its individual causes and effects are placed centre stage of the therapy. However, its *modis operandii* is more challenging than confrontative.

An important focus within the programme is to create a supportive, nurturing environment for programme participants. This is achieved in a number of ways. At a basic level the programme provides a regular daily structure wherein participants arrive, have breakfast, work in formal sessions, have tea / coffee, have individual discussions with members of staff, and leave. Participants spend a lot of time working in groups, which have developmental and therapeutic functions: groups work together in learning tasks, in making sense of new information, analysing it and doing things. The programme's educational components provide a focus for group discussion on vocational needs and aspirations. Groups also work together in developing and analysing their strategies for avoiding problematic drug use. This, indeed is perhaps the most important component of the programme as it involves participants planning and reviewing their progress in rehabilitation in a concentrated, pragmatic manner. TRP staff plays an important role in group facilitation and maintenance. This happens in both pre-arranged formal sessions and during less structured encounters: breakfast, coffee and recreational outings.

Staff constantly interact with the group; they add to its discussions, most often in a non-directive way in order to build and encourage motivation, but they also intervene directly to maintain group safety. Staff are also involved as keyworkers, providing practical assistance, advice, encouragement and support. Two members of staff provide more in-depth counselling, as required. In addition to direct contact work, staff are also engaged in planing sessions, reviewing individual and group progress, team building and supervision. They are also engaged in drawing up and testing procedures and standards for ongoing programme development.

Participants on the programme are persons whose drug problems have stabilised: most are on methadone maintenance. In the broader literature the programme might justifiably be described as an ancillary component to methadone provision. This same literature argues that the most effective methadone programmes have high quality ancillary services and that programmes with minimal psychosocial services may risk losing clients to treatment, thereby reducing their overall effectiveness. This is particularly the case for methadone programme participants who have intense needs. It is clear from an analysis of the data collected from TRP's current participants, that, in the main, it is expressive of deeply felt needs and the

exigency for a concentrated ancillary programme of counselling, combined with group development and other social supports is indicated. The data also reveals clear indications of progress in terms of dealing with the issues that underlie participants drug problems. In particular the programme's value in helping participants to understand addiction, its effects on both them personally and on the dynamics of family and other relationships is highlighted.

Also participants report progress in gaining this understanding through a process of therapeutic engagement rather than through single therapeutic episodes or events. In this process, many have dealt with personal issues and report changes in their confidence, self-esteem, their ability to deal with others and in their capacities to seek further integration within their families and communities. In particular, it is clear that participants articulate an understanding of their need to do more than stabilise through methadone and to seek ways of making other changes, particularly cognitive changes in the way in which they understand their problems and the resources that they can bring to seeking resolution.

While the project's overall focus on group development provides a coherence to the therapeutic programme, especially in terms of its daily attendance structure, there are indications that participants attribute a lot of the programme's success to individualised attention and there is a clear demand for more of this. As highlighted at the outset of this summary, drug taking is fundamentally a psychological act, and the route to recovery, however defined, requires some cognitive, behavioural change, achieved through individualised counselling and support. Alongside methadone maintenance, TRP's group programme provides the conditions whereby individual change and growth can take place. However, change is ultimately a personal decision, and to affect this change a highly personalised programme of assistance is often necessary. As the TRP programme grows and develops it is likely that it will need to incorporate, alongside its groupwork and educational components, more dedicated counselling and psychotherapeutic supports, provided not as an optional extra, but as an integral component of programme participation.

TRP's programme is attached to a vocational support programme, CE, which is specifically focused on getting long-term unemployed person's back into the labour market. Indeed, participants on such programmes are counted as off the live register and in employment for the purposes of national employment figures. There is a great deal of flexibility in the CE programme, thus allowing sponsors (i.e. TRP) a lot of flexibility in programme design. Various other CE schemes are specifically focused on work outputs. For example, these could be quantified as the number of meals cooked; the number of plants sowed; the number of customers served in a shop, etc. With TRP the outputs are a lot more subjective and not always very tangible, i.e. achieving progress in one's own rehabilitation and also these outputs don't lend themselves to standard assessment.

It would seem that there are a lot of benefits to being part of a vocational-oriented programme, particularly as rehabilitation ultimately involves a reintegration into mainstream society and a re-engagement with its norms. Vocational behaviour is normative and clearly any long-term objective assessment of the achievement of rehabilitative aims might include whether or not vocational reintegration has been achieved. This particular aspect of the programme provides concrete opportunities for expanding the project's aims and vision. Although, for a number of participants full reintegration into the labour market seems

unrealistic, nonetheless, work remains a tangible yardstick for participants and project personnel alike to appraise outcomes. The project therefore might consider how the vocational dimensions in the programme could be expanded: to combine a therapeutic / educational content with the practices and procedures of a typical work environment. In particular, the last four months of the programme (or an additional extension programme) might be considered as a period during which participants could undertake a practical work or service placement. Initially this might be for 8-10 hours per week, gradually increasing to 16 hours by the end of the programme. Remaining hours could be spent in TRP, continuing with centre-based activities. This would involve a phasing out of direct engagement with TRP and potentially preparing the ground for participation in an after-care programme.

The main value of including both therapeutic and vocational components in this type of arrangement is that at the end of the programme, there is a clearer sense of closure, of preparation for work as well as preparation for life. Participants also might have a clearer sense of contributing to society's overall output and service to the community. In this regard it would be particularly useful to put into place a mechanism for undertaking a longitudinal follow-up of project participants, particularly the current group who were interviewed for this report and to assess their progress in relation to employment and other matters, say after two, four and six years.

The procedures for participant intake onto TRP are quite straightforward and stated, particularly in relation to assessing levels of stability with respect to problematic drug intake. There is however, room to improve these procedures. First, given the various comments above in relation to longitudinal research and assessment, the project would be advised to utilise a standardised instrument as part of the initial assessment process. For Example, Maudsley Addiction Profile (MAP) or Addiction Severity Index (ASI) could be administered either directly by project personnel or by contract arrangement with an external, independent consultant, thereby setting a baseline for further data collection and analysis periodically, as well as providing additional information for assessment purposes.

Second, given the overall importance of individualised attention through keywork and counselling it would be useful to give deeper consideration to comprehensively assessing new entrants' needs and capabilities. These are likely to span drug-related aims, relationship aims, work and various other integrative aims and objectives. This should involve some detailed profiling leading to an outlining of the specific aims and objectives with respect to each individual participant alongside those of the group in general. The contract with participants could as a result be quite specific with respect to these aims and objectives; thus emphasising a sense in which the programme is both individually tailored as well as group based. In keeping with this approach it would be useful to have in place a coherent structure for ongoing review and monitoring. During the period of fieldwork for this report it was clear that there was a need for structured reviews for each participant, in which they could participate in appraising progress and re-setting aims and objectives. In recent months such review meetings have been introduced. These should take place at least quarterly during the course of the programme.

Third, there is a case for seeking a deeper involvement from referrers in monitoring and reviewing the progress of any individual participant. Ideally, external referrers should be

advocates for participants, assist in agreeing intake contracts and be involved in any formal reviews, as well as playing a more integrated role in relation to participants' termination of their involvement with TRP. The whole process of assessment, intake, management and discharge within a service should ideally become a shared responsibility between TRP and other actors across the various *Service Elements* of the local treatment system, as described in Section 2 above. Given the intensity of their therapeutic and everyday relationships with programme participants, it is important that TRP decisions in relation to intake and discharge have external input. There are furthermore, wider considerations to this discussion. As outlined in Section 2 there are two dimensions to local coordination of drug services: one involving mechanisms for identifying gaps in service provision and for mobilising responses, as appropriate. The second dimension concerns some form of coordinated case management. Given the rather complex nature of the range of different services for drug users it would seem appropriate that each service user has a designated case manager. This does not seem to be the case. In recent months the health board has appointed an overall rehabilitation coordinator. It would seem appropriate that in due course a team of case managers be developed through the coordinator's office perhaps through assigning case management roles to existing personnel. In such instance, it would be expected that these would have a critically important role in linking in with TRP's intake, assessment and review systems.

TRP is staffed by a highly committed team of workers who, are highly regarded by programme participants. It is evident that members of staff generally enjoy warm supportive relationships with programme participants. Although participants are openly critical of some aspects of staff engagement with the programme it is clear that in the main, these relate to teething problems and that staff have been able to take the criticisms on board in reviewing and adjusting the programme. The overall professional qualification level of staff however, is quite low. Increasingly in the filed of addictions it is recognised that a key factor in relation to successful outcomes is the training and quality of staff and that a related factor is staff insight into the range of treatments available and their knowledge of what works for different people. Clearly, an emphasis on staff training and development is important. TRP supports staff in undergoing in-service training and this is welcome and needs to be continued.

It is very evident that the central figure in the project's development is its manager, who brings assured leadership and confidence alongside particular therapeutic and counselling skills to the project. The manager commands respect both within and outside the project and although externally the project has attracted criticism, there is a strong sense of respect for its manager. The downside is that there is a lot of dependence on the manager and some of the project's overall programme and day-to-day procedures have developed in the absence of structure, relying greatly on manager's experience and willingness to deal headlong with unanticipated problems and difficulties.

The main working structures of the project have evolved. This is not unusual. There is no prescription for a project of this type and essentially formalities emerge as the project develops and grows. However, there is a need to pay clearer attention to formal structure, thus ensuring that it is possible to properly trace how decisions were made and that there are proper, accessible records of these decisions. Team meetings, staff supervision, review meetings and discussions are all part of this. – more structure is needed. In some respects routine management procedures are eschewed, particularly in terms of properly recorded

participant reviews, team meeting and personnel supervision. As already mentioned, there is a need for participants to be making clearer plans about where they are going together with procedures for monitoring and reviewing progress. There is a need for participant goals to be spelt out more so they could then be appraised on an individual participant, basis. Likewise there is a need for staff to be given more stated functions and responsibilities and for these to be monitored through a supervision / accountability procedure (performance appraisal). These are needed not only for the purposes of establishing full and proper records of project development but also to afford protection against possible claims of inconsistent decision-making (favouritism).

There is a view that there is a core group within management who have made a lot of commitment to attendance and who have been very supportive of the manager. Overall, it would seem however, that management committee is a bit isolated from day-to-day programme and its decisions. There needs to be more effort to ensure that overall management committee develops a clearer sense of ownership of the project and is contributing to developing the programme and its ethos. Furthermore, important issues in the long-term concern the need for a larger premises and a larger participant group. There is also a need for the work to be influenced more directly by the viewpoints of external agencies and bodies, and for the project to more directly seek these out in the wider community. The project and its staff should not be expected to take on these developments on their own. It is important that they be seen to have a strong, supportive management who assert a more collective ownership of the project and protect its staff from the possibility of isolation in their quest for better facilities.

From the above discussion and the detail in earlier sections of this report it should be clear that the development and operation of TRP has generally been a very positive experience both in terms of its success in mobilising the resources and energies necessary for setting up and initiating a programme of therapeutic intervention for drug users, *and* the way in which participants have valued and drawn benefit from the programmes' various components. In its first 18 months, of 61 referrals, 30 commenced the programme of whom 19 were considered to have been successful placements. Overall these figures might seem small in terms of say the number of persons who are on methadone maintenance (600). However, these need to be put into context. For example, through its referrals the project has had direct or indirect contact with at least 10% of known problem drug users in Tallaght during its first 18 months. Three per cent of known users have had a successful therapeutic engagement with the programme during this period. As time passes this - as this report is being written a new cohort of 16 participants have commenced the programme – the overall percentage of known problem drug users who will have availed of the programme will increase and in due course the project should become more established as an integral component of local drug services. The implementation of recommendations summarised below should help the project to consolidate and sustain its involvement in drug rehabilitation.

Conclusion and recommendations

-   The project's location and development within the context of a community base and management is an important acknowledgement of the significant influence of local social context with respect to drug problems. This community dimension needs to be continued and enhanced through both improved physical facilities in the community and a greater integration with other community bodies, for example the local drugs task force.

-   The project's long-term development is clearly linked to its engagement with other agencies and bodies who are involved in drug treatment and other related services. On a daily basis much of this engagement is undertaken through staff contacts and discussions. In the long term however, staff may have but a limited role in relation to the project's wider institutional integration. This is a role for management. It is recommended that management become more directly involved in the project's long-term development., through initiating a process whereby it can plan and put into effect a development plan, perhaps for the next five years.

-   The project needs a new mission statement that reflects both its community dimension and its practice, informed by public health principles, of assisting drug users to develop an understanding of their problems and to learn new ways of managing relapse and avoiding a return to problematic forms of drug use.

-   In addition to developing a new mission statement the project also needs to design a new brochure / leaflet that spells out more clearly its rehabilitation programme: aims, structure and content, in a manner that clearly articulates the programme's potential to complement and add value to other programmes and services, ranging from outreach to treatment, dealing with drug uses in Tallaght.

-   The project needs to undertake an intensive exercise in explaining the project to other community bodies and services within Tallaght and in developing further relationships for future referral and ongoing collaborative, therapeutic and educational interventions. The project also needs to involve referrers more in ongoing programme development.

-   As part of its initial assessment of prospective participants the project should use a standardised instrument (of known validity and reliability) such as Maudsley Addiction Profile (MAP) or Addiction Severity Index (ASI). The administration of an instrument could be undertaken directly by project personnel or alternatively it might be appropriate that it be utilised as part of a longitudinal research exercise.

-   Also as part of its initial assessment the project needs to draw together more comprehensive information on prospective participants with an emphasis on assessing individuals' strengths, problems and needs and in identifying a programme of intervention individually suited to responding to these needs.

- It is recommended that at the outset of programme participation a comprehensive plan and agreement be reached with each participant and that this set out the basis for ongoing monitoring and review and that such reviews be undertaken at least quarterly.

- It is also recommended that referral agencies and / or personnel have a more direct role in assessment, monitoring and review procedures. Such persons should be directly involved in consultations with prospective participants as part of the assessment process: they should be part to agreements and have a participating role in reviewing progress on a periodic basis. Critically, they should also be directly involved in drawing up arrangements for aftercare.

- Given the wide range of services and personnel involved with the project's target group there is a clear argument for more intense case coordination between and among the services. Given its role as providing a therapeutic programme TRP is in a unique position to iniate and support a process of case coordination. Initially, this might be developed at the level of discussion and exploring issues in a general way, eventually, and hopefully, leading to the development of mechanisms (and protocols for confidentiality, etc.) for dealing with the issues in a particular sense.

- The project needs to improve the extent and level of individual components in the programme, particularly in terms of undertaking more in-depth assessments, designing individually tailored programme components and developing more opportunities for further individual counselling and / or referral to more intensive psychotherapy, as appropriate.

- The project needs to undertake a deeper appraisal of the vocational dimension to the programme and to explore whether this component provides deeper opportunities for rehabilitation. This could be undertaken through developing a placement component to the programme whereby participants spend some time either in a work or local service agency, either within the context of current programme duration or as an additional stage to the current programme.

- There should be comprehensive training, supervision and support for all staff who work in the field of addictions. It is particularly important that staff be familiar with a range of addiction treatment models and also that they understand the multidisciplinary nature of the work and the professional boundaries of expertise. TRP has made a big commitment to staff training. However, staff's overall level of qualification is quite low so it is particularly important that they continue to invest in staff training and development.

- Many of the project's procedures and structures have evolved. These need to be formalised. Clearly, as already mentioned, a formal procedure for reviewing participants' progress is required. So too are more formal procedures for team meetings, routine decision-making and personnel supervision. It is recommended that that such procedures be put into place.

Finally, this report clearly stresses the interplay of economy, society, culture, family and community and their effect on the everyday experiences and choices of drug users, thereby emphasising that alongside individual change, there is the need for social, environmental and cultural change within the context of a wider political-economy. In recent years the Irish economy has improved and there is some evidence that these improvements have had some impact - in terms of employment and income - in those neighbourhoods that were worst affected by drug problems. These changes provide drug users with evidence of alternative lifestyles and they also have the effect of stifling the demand for illegal commodities in a local drug economy, creating extra pressure on drug users to seek treatment. In due course these developments will influence the nature and shape of drug problems thereby causing drug services to constantly re-assess their role and contribution.

Drug treatment and rehabilitation policies have changed quite dramatically in recent years, reflecting wider social and economic developments. Future policies will continue to reflect the dynamics of change. TRP ultimately wishes to be able to influence the course of these changes. To do so the project needs to continue to account for its progress. This report will assist the project in this task. However, much of the data in this report is retrospective and was collected within a relatively narrow framework and short timescale. Although this report provides the project with an important baseline account of its emergence and initial stages of development, the project would, nonetheless, draw immense benefit from a more long-term study that could, as a consequence, generate important position papers with respect to drug policy issues, as and when required. It is recommended therefore that the project initiate a process of prospective data collection in the form of a longitudinal research and evaluation exercise. Fundamentally this recommendation builds on the project's evident commitment to engage in a structured critique and review of progress.

ENDS/………..