

**Drugs Task Force Project Activity for FAS
Community Employment and Job Initiative
Participants**

A Review

**Dr Alan Bruce
July 2004**

***Universal Learning Systems
34 Charleville Road
Phibsborough
Dublin 7***

Table of Contents

1. Background	4
2. Overview of Drugs Issues and Policy Responses	8
2.1 International Responses	
2.2 American Perspectives	
2.3 European Perspectives	
3. National Contexts and Role of FAS	28
3.1 National Background	
3.2 Origins of the FAS role	
3.3 Operation of CE	
4. Drugs Task Force CE Projects –Structure and Profile	37
4.1 Project profiles	
4.2 Cork schemes	
4.3 Project issues	
5. Consultation with Stakeholders	47
5.1 Sponsors and individual project staff	
Perceptions of FAS	
Administrative concerns	
Appropriateness of labour market orientation	
Rehabilitation or training	
Therapy and guidance	
Premises an resources	
Structural complexity	
5.1.8 Learning from others	
Project participants	
Escaping the chaos	
Self-esteem and confidence	
Educational issues	
Recognition	
Future prospects	
Childcare	
Independent living	

FAS and Community Development Officers

Variation in schemes

Appropriateness of CE for target group

Issues on standards

Developing project capacity

Resources and skills

External linkage

External views

Specific Recommendations

6. Projects – Themes and Processes 80

6.1 Themes

6.2 Impact of changing addiction scene on service provision

6.3 Lack of inter-agency approach

6.4 Organizational confusion

6.5 FAS quality assurance for schemes

6.6 Role of schemes: client expectations

7. Conclusions 86

7.1 Best practice

7.2 Inter-agency focus

7.3 Outcomes for participants

7.4 Operational issues

8. General Recommendations 91

9. Bibliography 94

1. Background

In response to the overall objective of the National Drugs Strategy of reducing harm caused to individuals and society by drugs misuse, FAS set aside a budget of 1000 Community Employment places in 1997. This was designed to support and assist drug misusers in their preparation for and gaining access to the labour market. This response was designed to be part of an interagency focus on prevention, treatment, rehabilitation, training and education for the individuals concerned so that they could be enabled to have independent, socially and economically sustaining lives.

FAS services had always been available to people who came through a rehabilitative process. The provision of Community Employment did not reflect the total FAS input to the designated client group. In view of the issues arising, the commitment under the Programme for Prosperity and Fairness for an increased provision of places of 30% by 2004 and the impending setting up of ten regional Drugs Task Forces it was decided in late 2003 to undertake a review of the FAS involvement in provision in Community Employment Drugs Taskforce Places.

This Review was designed to provide:

- An overview of the drugs issue from the perspective of best practice nationally and internationally, with an outline of the main themes and concerns with the full involvement of the community and voluntary sectors.
- A review of national policy
- An identification of the key stakeholders and their roles
- An outline of the current structure of Drugs Task Force Community Employment projects with respect to the roles of the main

stakeholders, the effectiveness of the intervention regarding integration, the levels of progression and the qualitative aspects of programme delivery from the perspective of participants and sponsors.

- A review of operational processes with regard to referral, assessment, procedures and follow-up.
- An analysis of the relevant roles and responsibilities.
- An analysis of the outcomes from the point of view of the stakeholders involved.
- A set of observations regarding the balance between rehabilitative and training orientations in programme interventions.

The Review Terms of Reference, in addition, detailed three key questions that were intended to inform the course of investigation.

- 1) Is Community Employment achieving the overall aim and objective of progressing participants into labour market related activity? Is it the most effective way to do this?*
- 2) To what extent do the objectives of Community Employment fit with the broader remit of the Drugs Task Force? How does CE interface with other agencies involved in the process?*
- 3) At what stage in the rehabilitative process should a labour market program be introduced? What is the sequence of progressive stages for an individual?*

These questions highlight the key themes that recur throughout the Review:

- Progression
- Labour market orientation
- Rehabilitation and personal needs
- Agency linkage
- Responsibility and role clarity.

In the interlinked areas of substance abuse, addiction and recovery a variety of complex factors needs to be taken into account before considering programmes for transition to some form of labour market activity. Interventions need to take in the need for extensive dialogue between health professionals, education and training specialists, families, communities and the voluntary sector – as well as those enduring addiction themselves.

The challenge evidenced in research nationally and internationally is to address addiction while at the same time enhancing the educational, social and vocational competencies of the person. The goal is, using a variety of coordinated methods, to transform lives from dependence to independence.

The issues involved for individuals experiencing addiction include levels of health and motivation in addition to levels of skill and education. They also include factors often linked to social deprivation, homelessness, social welfare status, relapse, legal issues and prison records, childcare, broken family relationships, literacy, stigma and poor levels of personal confidence and self-esteem.

A changing labour market also means changing standards of qualifications and skills to meet new occupational requirements. This places a strong emphasis on educational and academic competencies.

This Review focuses on four main perspectives:

- Individual needs and personal expectations (participants)
- Community needs: expectations and resources
- FAS specific issues
- CE project requirements.

The Review methodology encompassed:

- Literature and policy reviews
- Reviews of international best practice
- Data analysis
- Project visits and personnel interviews (18 projects)
- Focus groups of participants (4)
- Sponsor meetings and interviews (4)
- Meetings with FAS and Community Development Officers (6)
- Specialist agency meetings and interviews (8)
- Individual participant interviews (12).

An initial meeting with the National Drugs Strategy Team was held in Dublin on 16 March 2004. An interim report was presented to this group on 21 June 2004.

.Extensive support was received from FAS throughout the review process. Particular thanks are due to Ms Mary Donnelly and Ms Miriam Conway.

2. Overview of Drugs Issues and Policy Responses

2.1 International Contexts

The profound changes in Irish society in recent years encompass a range of issues connected to dynamic levels of economic growth, improved living standards, improved employment opportunities, the end of mass emigration (indeed the growth of net inward migration) and the emergence of a young and better educated population. Amid these positive developments, however, there continues to exist a range of social and economic problems. These include persistent levels of poverty, homelessness, marginalization and substance abuse, particularly in certain urban areas.

In many ways Ireland remains a deeply stratified society. Available evidence shows differences in income and access are actually increasing. In many communities, pockets of long-term unemployment co-exist with a strong sense of disempowerment and hopelessness. The impact of drug abuse in such communities can be catastrophic both in the implications for individual self-worth and in the implications for communities of illicit and often menacing distribution systems.

The Government has made social inclusion a policy priority in addressing these issues. In a range of various social partnership initiatives (*National Development Plan 2000; Programme for Prosperity and Fairness 2000; National Anti-Poverty Strategy*) it has allocated significant financial resources to combat poverty and social exclusion and to ameliorate the disparities identified.

The Government's approach to substance abuse and addiction is embedded in this broad social inclusion framework. Linkage between social exclusion or

impoverishment and levels of substance abuse has been strongly recognized in various national initiatives in this area. While addiction is a generic concern, drug abuse has an added resonance when taken in the context of poverty and social marginalization.

Among the means to tackle this in Ireland are a number of strategies:

- Development of an integrated inter-agency approach
- Devolving power to tackle exclusion to local and regional authorities
- Local community participation in the formulation and implementation of policy.

These strategies emerge from an *international* debate on the role of education and training in promoting social inclusion. The process of globalization and technological change affects all countries. The development of new skills and competencies to participate in this new environment is a major prerequisite for all countries.

However, for those marginalized by a range of historic socio-economic factors and issues, a variety of additional factors may be identified. Ironically, the general international trend towards a knowledge and skills based society can act as an additional barrier to those marginalized by poverty, poor formal attainments and a lack of access to the skills and competencies required to secure a place in the open labour market.

The **International Labour Organization** has recognized that vocational training and human resources development (defined as activities of education, initial training, continuous training and lifelong learning that develop and maintain individuals' employability and productivity over a lifetime) benefit individuals by developing and maintaining employability and adaptability in a labour market that is continuously changing.

Training and development are seen to provide a series of benefits:

- Improving prospects of finding and retaining employment
- Improving productivity at work
- Improving income and living standards
- Widening career choices and opportunities
- Developing new skills and competencies for enhanced social participation.

A key aspect of this is, in the view of the ILO, the promotion of social justice and equality of treatment in employment.

Education and training have an important role to play in promoting labour market integration and the social inclusion of population groups that face discrimination... However, education and training cannot by themselves solve the problems of unemployment and underemployment, and poverty and social exclusion. In order to be effective, they must constitute an integral element of economic and social policies that promote employment intensive and equitable economic growth and progress.

(ILO 2000, p. 3)

The ILO connects issues of social exclusion to specific issues of youth employment and the concerns that arise from poverty and chronic marginalization. The ILO recognizes that unemployment and poverty are correlated to levels of exclusion through disability and drugs abuse. It is acknowledged that worldwide a disproportionately large number of young people are exposed to long-term unemployment or are limited to precarious short-term work or poor quality low-income jobs.

As a consequence, large numbers of young people drop out of the workforce or fail to enter it in the first place and become inactive. Socially disadvantaged youth are particularly affected. This perpetuates a vicious circle of poverty and social exclusion.

Discrimination contributes to these levels of unemployment and inactivity. The most socially disadvantaged experience more problems, are less likely to attain good basic levels of education and often experience direct discrimination as a result of class, ethnic origin, disability, gender, etc. The cycle of exclusion and failure is powerfully reinforced when chronic substance abuse becomes part of the equation.

In several advanced economies youth joblessness is more and more concentrated in households in which no member is employed.
(OECD 1994, p.94)

The international literature emphasizes that the diffusion of new technologies and globalization are raising the demand for workers who possess higher levels of education, skills and competencies. This puts a premium on work experience and attitudes which even well-educated labour market entrants may lack. Consequently a major task for public policy is to provide adequate and appropriate support programmes parallel to education and training initiatives. These include vocational guidance, counseling, job search assistance, psychological supports and income supports.

These supports, often seen as under-resourced or inadequate for mainstream job seekers, take on a qualitatively different dimension when considered in the light of the needs of those who have developed significant levels of substance abuse and addiction. They put in context the urgent need for adequate resources, planning and coordination to ensure that the needs and stark realities of life for those excluded by reason of drug addiction are faced in a comprehensive and humane way.

If employment is a valuable resource in promoting integration, unemployment can act as a powerful reinforcement of exclusion.

The consequences of youth unemployment, underemployment and inactivity are well documented. Unemployment in early life may permanently impair young people's employability as patterns of behaviour and attitudes established at an early stage will tend to persist in later life. Their exclusion from work experience and access to continuous training also increases their difficulties in finding jobs later. ... The exclusion of young people from a productive role in the adult world of work can demoralize them, undermine social cohesion and lead to social problems such as crime, drug abuse, vandalism and general alienation. Effective education and training policies, coupled with support programmes and appropriate macroeconomic policies to stimulate labour demand, merit high priority in all countries.
(ILO 2000, p. 32)

The impact of substance abuse and addiction on the lives of individuals and families is well documented. The catastrophic consequences for individuals of lives of chaos and marginalization produce a high cost to society in many aspects. It is important also to regard the implications from the perspective of the labour market.

Key Learning Points

In addressing issues of addiction from an employment outcomes model international research underlines new challenges for public policy from:

- The impact of globalization
- The emphasis on competencies – education and training
- The key and interlinked roles of employers and the community
- The impact of discrimination
- The importance of adequate supports

2.2 American Perspectives

In most rehabilitative formulations of responses to addiction and drug misuse, the use of training and work to secure meaningful employment outcomes is regarded as an essential element for successful interventions. The locked cycles of deprivation, poverty, exclusion and unemployment are not inevitable concomitants of the experience of drug abuse. They can be broken by the adoption and implementation of coordinated responses based on a balance of vocational interventions and rehabilitative supports. The country with some of the most developed models in this field is the United States.

Whatever about policy trends and popularized campaigns from time to time that emphasize a quasi-military response to drug misuse (a 'war on drugs'), many States have developed sophisticated intervention programmes that link rehabilitative efforts with labour market outcomes. Under Federal drug abuse and alcoholism grant programmes, States have central agencies (usually within Health Departments) that prepare plans and coordinate and conduct projects for drug abuse or alcoholism prevention and treatment. Any public or private treatment facility in a State that receives Federal assistance must meet the standards of such agencies.

Federal administrative responsibility is located in the **National Institute on Drug Abuse** (NIDA). NIDA provides extensive research on intervention programmes together with a range of publications. It has, for example, developed a ***community reinforcement*** approach to addiction that contains the following elements:

- Lifestyle changes
- Counselling style and techniques
- Behavioural issues
- Initial assessment procedures

- Drug avoidance skills
- Time management
- Social skills
- Vocational counselling and goal setting
- Health and abstinence.

These themes inform best practice in preparing individuals for independent living and drug free lifestyles and are viewed as critical in job preparation – itself viewed as a key component in moving to a drug free lifestyle (NIDA 2003).

Satisfying, gainful employment or career activities can play an important role in achieving and maintaining abstinence from cocaine and other drugs of abuse. A job counselor is available to work with patients throughout the week, and therapists use Job Club procedures in individual counseling sessions when appropriate. In drug abuse treatment, one of the predictors of long-term success is stable, satisfying employment.

The primary goal of vocational counseling is to assist patients in finding satisfying employment or in taking steps toward the development of a meaningful career. Therapists first conduct a thorough assessment and then collaborate with patients to set behavior-change goals. These goals should be monitored and changed, as needed, until patients achieve their long-term goal. In this respect, vocational counseling is typically an ongoing component throughout treatment.
(Budney and Higgins, 2003)

The **Substance Abuse and Mental Health Services Administration** (SAMHSA) operates as part of the **National Clearinghouse for Alcohol and Drug Information** (NCADI). It produces a range of excellent research resources and publications. These publications develop the links between rehabilitative and vocational - or employment - related outcomes.

For many years, US researchers have acknowledged the specific difficulties entailed in providing effective service interventions for populations with substance abuse and addiction problems.

The usual, traditional approaches to job training have serious limitations when applied to the substance-dependent population. In addition to a lack of skills, there is frequently a lack of motivation and general education as well. This is further complicated by the attitude of many employers who screen such people because of their addiction or arrest record. There is also the special situation of addicted individuals who may have additional limitations (e.g. psychiatric disabilities).

(Wright 1980)

SAMHSA has produced a set of **Treatment Improvement Protocols** (TIP) that examine approaches to issues of rehabilitation and training for substance abusers. One such TIP (Series 38) examines issues of treatment as they relate to employment and vocational services (*Integrating Substance Abuse Treatment and Vocational Services*).

This strongly advocates an ***integrated and collaborative effort among agencies*** and service providers to meet the range of needs of clients. It feels that when agencies working with substance abusers work independently of each other the result will be clients subjected to fragmented services, thus creating frustration and confusion.

The Protocol advocates an effective referral system based on the following three key principles:

- ***A shared vision*** – to facilitate strategies to achieve common goals. This is deemed central to achieving quality in community health care systems and cost-effectiveness of the care provided.
- ***Collaboration among agencies*** – to prevent service fragmentation, client drop-out and lack of contact between professionals involved.

- **Designation of one agency as the primary contact** – to enable holistic assessment, improve efficiency and maximize communication among different agencies to secure meaningful employment outcomes.

Structural barriers may be posed by programme policies that are determined by the programme's primary funding source. Such policies may dictate, for example, that clients cannot engage in concurrent activities such as vocational training and treatment of substance abuse disorders... Substance abuse treatment that is both client-focused and client centred is more likely to improve the lives of clients. Collaboration among agencies providing requisite services is an initial step toward client-centred care.

(SAMHSA 2003, p. 6)

This suggested model is seen as one where collaborations are fostered and maintained among agencies providing services to clients with overlapping needs (such as substance abuse treatment, employment, housing, education and child care). Such a model is driven not only by a qualitative focus on strategic vision but also by recognition that employment outcomes are the surest method for long-term success for individuals and communities alike.

In this context, the SAMHSA literature emphasizes that services and activities provided by organizations need to be evaluated to determine how they contribute to such outcomes. The two elements of **programme assessment and staff development** are the critical identified factors in capacity building in the sector. While the role of adequately trained and accredited staff is universally mentioned throughout the US literature on substance abuse interventions, the need for programme investment and clarity is deemed equally important.

As an organization begins to engage in capacity building, it will find that its initial costs may be higher than the old method. Programmes and funders need to be educated that in the short run the new authentically connected referral model will be more expensive...However, once the network is in pace, it will maximize the use of funds by avoiding duplication of services and, most important, it will result in higher client rehabilitation success rates. (SAMHSA 2003, p. 8)

The US literature, particularly that from a rehabilitative viewpoint, is aware of and sensitive to issues of context. While techniques aimed at transition to employment are well-researched and evaluated, it is recognized that substance abuse poses particular problems because of its complex nature, impact on individual lives and impact on communities. A key issue identified has been the link to poverty.

The statistics are clear that most people with disabilities and people with dual diagnoses (disability and substance abuse) exist on incomes that are consistently below the poverty level. **Poverty** is regarded by Menz as perhaps the clearest condition associated with disability and the unemployment of people with disabilities (substance abuse and addiction are subsumed under the category of disability). Poverty is seen as the cause and effect of disabilities in the physical, social, medical legal and other conditions so closely associated with it.

Poverty is established in our urban and rural communities and is populated by individuals linked by 'lacks' that in turn create allegiances, define citizenship, establish lifestyles, determine roles and result in common economic and health conditions. It is governed by need and scarcity of opportunity and inertia. In a sense, poverty is a culture...transferable from community to community and generation to generation.

(Menz 1997, p. 51)

In this context Menz and other authors do not propose rehabilitation as a 'cure' for poverty. But it is recognized that rehabilitative interventions can and do move people with disabilities and disabling situations (like substance abuse and addiction) out of many of the social, health and economic conditions that sustain individuals in poverty. Rehabilitative interventions do not view the individual in isolation from broader needs.

In looking at the specific matrix of substance abuse and drug addiction, Menz identifies a number of significant factors that need to be taken into account in developing ***effective strategies for vocational progression***.

These include:

- Professional attitudes towards difficult areas like drug abuse
- Professional reluctance to encourage individuals to pursue vocational goals
- Perceptions that there are few vocational alternatives
- Poor training and qualifications of community based personnel (including job coaches and work supervisors)
- High levels of stress, burnout and turnover in community based staff
- Lack of supports for staff
- Lack of technical and communications skills in personnel.

(Menz 1997, pp. 76-81).

The wealth of independent university based research in the United States means that a variety of programmes can be reviewed and evaluated. Thus they serve as useful case studies in looking at training programmes for those with substance abuse problems.

A key and growing problem has been the growth in numbers of those labeled 'dual diagnosis' – that is with both psychiatric disabilities and drug abuse issues. The close correlation between drug dependency, poverty, social exclusion and weakened health makes this an unsurprising category. There are close parallels between the effects of drug misuse and many psychiatric disabilities, as well as parallels in the treatment protocols and vocational rehabilitation interventions that have been developed for both categories.

One of the most pro-active psychiatric disability service providers in the United States is **Thresholds**, based in Chicago. Thresholds has developed innovative housing, assessment, supported employment and vocational training strategies over many years. It works closely with city, State and Federal agencies. It also has a comprehensive research department which has done extensive work on the ***evaluation of strategies*** that facilitate occupational re-integration and health stabilization.

Findings include:

- The benefits of integrating educational services and supports into vocational programmes
- The need to have on-site learning supports for staff and clients alike
- The importance of paid job training placement systems coupled to relatively rapid placement of persons into jobs
- The need for ongoing availability of workplace based job supports and assistance
- The benefits of using of self-help and peer-delivered services.

(Cook, Bond, et al. 1994).

Thresholds' vocational training programmes have had some degree of success for clients with severe levels of psychiatric disability and substance abuse. But a range of parallel services has been identified as essential. The lessons, while generally positive, have not been replicated outside the greater Chicago area.

A qualitative analysis of community integration through rehabilitation by Judith Cook of the University of Illinois in Chicago raises these concerns.

Findings indicate that vocational performance deteriorates over time without assistance and this suggests that more attention should be paid to designing long-term vocational services than has previously been the case

in program planning... Another strategy would be to add vocational rehabilitation services to the array of services offered by consumer run drop-in centres.

(Cook 1997, p. 299).

In all interventions around both psychiatric disability and drug abuse (and dual diagnosis) findings confirm complex relationships between employment outcomes and factors such as self-esteem and quality of life. Issues around stigma and feelings of profound marginalization go to the core of many subjective experiences of substance abusers.

In these vicious circles of exclusion and poor vocational attainments, interventions need to strike a careful ***balance between realistic vocational outcomes and therapeutic needs***. This is in addition to the disincentives to work present in individuals' current and future benefit eligibility that have been pinpointed consistently in the US research.

Finally, US experience demonstrates that additional research is needed on matters around public employment and disability policy.

This involves increasing our understanding of the ways in which changes in public policies influence access to rehabilitation services, entitlement income, health care and employment. More multi-site and statewide comparison studies are needed to address the effects of policy change at both macro and client levels. Also needed are exploration of ways in which capitated approaches to mental health care financing have both direct and indirect effects on rehabilitation and work outcomes for persons with psychiatric (and substance abuse) disabilities.

(Cook 1997, p. 303).

One of the most difficult problems policy makers and professionals face in the United States, and shared internationally, is trying to find programmes that move chronically unemployed and chemically dependent persons permanently from public assistance into open employment.

An example of good practice is the **VOTE** programme (*Vocational Opportunities, Training and Education*) which has been placing hundreds of these individuals into the economic mainstream while at the same time assisting them to remain 'clean and sober' since 1987 (Moyes and Hildebrant 1996).

This programme originated in the State of Washington following the enactment of its *Alcohol and Drug Abuse Treatment Support Act* (1987). From 1982 to 1986 the number of drug addicts on Washington's *General Assistance – Unemployable* caseload had increased from 1,200 to more than 6,000 – an increase of 400%. This represented a welfare bill of roughly \$45 million.

The VOTE programme is a seven-week vocational and substance rehabilitation programme located at one of two participating Community Colleges in the State (at Tacoma and Yakima). Satellite programmes are operated and VOTE staff work with participants to develop hope and excitement about returning to work. The programme simultaneously addresses unemployment and addiction issues.

The programme has two primary goals:

- *To support and enhance participants' continued recovery from substance abuse*
- *To facilitate participants' transition from welfare to open employment.*

Following referral and comprehensive assessment, participants attend classes and training interspersed with therapeutic interventions. The programme consists of:

- Self-assessment counseling
- Vocational aptitude and interest testing
- Employability determination

- Interviewing and networking techniques
- Life skills training
- Career planning
- Self-esteem development.

VOTE participants are also required to attend Alcoholics Anonymous or Narcotics Anonymous meetings at least twice a week, participate in structured job clubs and attend out-patient counseling. Integration within a Community College campus is a unique feature and judged a major success. Stigma is reduced considerably while the addition of educational credits and achievements facilitates individual recovery greatly.

Between 1986 and 1989 numbers on the *General Assistance - Unemployable* list dropped from nearly 6,000 to 2,800. VOTE has proven itself effective in disrupting the unemployment and relapse cycle. Placement rates to open employment or continuing further education are 75%.

By embedding such a programme in the educational sector, valuable resources were made available and the programme has now been extended to communities across the State – as well as to prisons and rehabilitative units. VOTE achievements were found particularly strong in the following areas:

- Workforce training
- Welfare to work projects
- School to work projects
- Vocational rehabilitation
- Improving work performance
- Team building
- Career development.

The US literature stresses the need for ***integrated and holistic approaches*** in dealing with employment related rehabilitative programmes for those with drug dependency issues as well as psychiatric disabilities. In stressing methodological clarity a recurrent theme in the US literature is the need for adequately trained and professionally qualified staff who are able to meet the variety of complex needs in the field.

The seeds of staff burnout are planted when mental health professionals who work with substance abuse or long-term mental health problems do not recognize that such people vary greatly in their potential for rehabilitation. This situation leads to unrealistic expectations and frustration for staff. The concept of normalization, if misapplied, can lead to the same result. Contributing to the frustration is administrative pressure on staff to produce the impossible.
(Lamb 1982, p. 211)

Key Issues Arising

American experience in rehabilitation and vocational training for substance abusers emphasizes the importance of:

- Integrated and collaborative effort among agencies
- Programme assessment and staff development
- Effective strategies for vocational progression
- Balance between realistic vocational outcomes and therapeutic needs
- Integrated and holistic approaches.

2.3 European perspectives

The European Union has developed both an *Action Plan on Drugs* (2000-2004) and *A Union Drugs Strategy 2000-2004*. The **European Monitoring Centre for Drugs and Drug Addiction** (EMCDDA) is the central reference point for drug information in the European Union. A decentralized agency of the EU, the Centre was set up to provide the Union and Member States with '*objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences*'.

By offering evidence-based information on drugs information within the European Union, the EMCDDA helps policy-makers, researchers and specialists in the field understand the nature of the problem and formulate appropriate responses.

At the heart of the Centre's work are efforts to improve the **comparability of drug information** across Europe and to devise the methods and tools required to achieve this. A key feature of the drug phenomenon is its shifting, dynamic nature. The statistical, documentary and technical information processed or produced by the Centre helps provide an overall picture of the drugs phenomenon in Europe. The Centre works exclusively in the field of information.

The information collected, analyzed and disseminated focuses on the following areas:

- Demand and reduction of the demand for drugs
- National and European Union strategies and policies
- International cooperation and the geopolitics of supply
- Control of the trade in narcotic drugs
- Implications of the drugs phenomenon for producer, consumer and transit countries.

The EMCDDA confirms a great variation across EU Member states in terminology and definitions. It recognizes that perfect harmonization of data is not possible because of the diversity of national data. The very idea of classifying and measuring drug treatment and social rehabilitation availability originates in the Union's *Drug Action Plan* (2000-2004). Its third strategy target is *"to increase substantially the number of treated addicts"*.

In various settings and forums it has become clear however that this is by no means an easy task and also that there is no direct way of shedding light on this objective. Instead the evaluation of this objective can only be made by looking at related issues such as measuring availability of treatment, presenting scientific evaluations, sketching expenditure on treatment facilities and so on.

(EMCDDA Final Report 2002).

The EMCDDA has done much work on seeking **definitional clarity**. It has also worked to provide a set of national 'snapshots' so that a comparative framework can be established. A treatment inventory has been developed which ideally should contain standardized information about treatment models in each country. In effect, however, information is not standardized.

Additional work by the Centre demonstrates that the term '**rehabilitation**' is used ambiguously across Europe – from low threshold refuges to normal treatment to actual reinsertion into society. The Centre tends to use the term 'reintegration' as this is more consistent in the various national environments. The Centre draws a firm distinction between this process of **social reintegration** and the concept of **social inclusion**. Social inclusion, it feels, is far too vague to encompass the steps needed to achieve meaningful and definable outcomes.

Social reintegration is defined as *"any long-term social intervention aiming at integrating former or current drug users into the community"*. In other words these are re-integrative efforts made in the community as a last step in the

treatment process – but with social objectives not treatment ones. This implies that first contact between the drug addict and treatment and rehabilitation services is not considered as social reintegration since it is not the last step in a treatment process. Social reintegration processes are classified as:

- Education (for example vocational training)
- Housing
- Employment (including subsidized employment).

The centre has also established the *Exchange on Drug Demand Reduction Activities* (EDDRA) - an extensive database on evaluated projects across Europe. EDDRA investigates individual projects with regard to initial assessment of needs, general objectives, referral procedures, responses to addiction, methodologies employed and client evaluation and feedback.

The variety of national experiences and responses in Europe means that it is far too early to talk about a common European response to substance abuse and addiction. There is little if any conceptual clarity or common ground – even in relation to common definitions. There is a wealth of comparative data however and the growing number of individual project evaluations fed into EDDRA is a rich source of knowledge and information. There is also a lack at European level of the kind of standardized and systematic research from independent universities informed by a common rehabilitative framework that one sees in the United States.

This has particular relevance when looking at staff qualifications and expected competencies. Some European countries run on heavily medicalized models. Others have adopted much more pro-active social and community perspectives. All lack a common professional rehabilitative model as articulated in North America.

A key contributor to European perspectives – and of relevance in Ireland – has been the funding of drug specific projects under a number of EU Community Initiatives such as Employment Horizon, Integra or NOW. These project strands have contributed to a number of Irish projects, helped initiate innovative responses and established transnational frameworks for collaboration.

Many individual European countries have developed innovative programmes, (some of which have collaborated with Irish agencies reviewed in the course of this Review). For language and proximity reasons some of these linkages have been established with British projects. One project in this review, for example, had the opportunity to visit the *Independence Initiative* in Liverpool that works with individuals, local authorities and the wider community to facilitate rehabilitation for people with a history of drug abuse and to provide family support. While these links and visits are useful, the lack of standardized contexts and concepts means that there is a risk of not comparing like with like. For the development of common professional insights and contacts such exchanges, however, can be invaluable.

Key Learning Points

European perspectives centre on:

- Information coordination and data analysis
- Comparative national frameworks
- Social reintegration processes: education, housing, employment.

3. National Contexts and the Role of FAS

3.1 National Background

Historically the drug problem in Ireland is a relatively recent one, particularly when compared with other European countries. Only in the 1980s did this become a very visible problem with a huge increase in the incidence of heroin use - even though this was primarily evident in certain disadvantaged communities in Dublin. Evidence shows that drug use continues to grow and the number of cases in treatment has increased steadily.

Accurate statistics are difficult to obtain. According to the most recent data in 1996 there were between 10,655 and 14,804 problem opiate users. If this is contrasted with the 5,032 in methadone treatment, between 34% and 59% are on methadone treatment (EMCDDA 2002, p. 39). In addition there is an unknown number in drug free treatment, either in-patient or out-patient.

Needless to say, while opiate abuse may be a relatively recent problem in Ireland, issues around addiction and abuse of substances have a long history. Alcohol, nicotine and prescribed drug abuse are significant issues for many thousands. In addition, other drug use (including marijuana, ecstasy and cocaine) is present and in many cases growing. The particular damage caused by the rapid spread of opiate addiction in deprived urban communities in Dublin and the associated health risks posed (especially in terms of HIV infection and AIDS) provoked a profound debate on strategy and policy from the 1980s on.

Policy throughout the decade was influenced by the findings of the **Bradshaw Report** in 1983 (produced by the Medico-Social Research Board) and the recommendations of the **Special Inter-ministerial Task Force**. Despite a strongly 'prohibitionist' approach, these reports recognized connections between

poverty and disadvantage and opiate drug use. They also referenced the potential role of community groups in tackling the issue. The drugs problem continued to grow and a fundamental shift towards more creative strategies only occurred in the 1990s.

The publication of ***The Government Strategy to Prevent Drug Misuse*** in 1991 marked a new strategy to set out realistic objectives within the contexts of a coordinated delivery structure geared towards treatment and rehabilitation. A key element of this strategy was the development of cooperation between the various interested parties: voluntary, statutory, education and community.

The Ministerial Task Force on Measures to Reduce the Demand for Drugs was established in 1996 with a remit

- To identify the nature and extent of drug misuse
- To examine underlying causes
- To examine the effectiveness of the current response to the drugs problem
- To examine the effectiveness of structural arrangements to deliver that response.

The Task Force produced two reports - in 1996 and in 1997.

In the ***First Report*** (1996) there was an emphasis on principles of coordination, coherence and integration and a consequent need for more effective collaboration between the statutory and community and voluntary sectors in the delivery of local drugs programmes. There was a concentration on the development of a range of structures to coordinate the development of drug services.

From this emerged the development of eleven Local Drugs Task Forces (LDTFs) in 1997 and the establishment of a National Drugs Strategy Team.

The **Second Report** (1997) concentrated on other aspects of the drugs problem such as non-opiate drugs, drug abuse in prisons, youth services and the role of therapeutic communities. While these reports have not been without criticism (Ruddle 2001), they laid the foundation for the current national structures and outlined the lines of policy debate and needs within which strategy has developed.

The overall objective of the National Drugs Strategy is to **reduce the harm** caused to individuals and society by the misuse of drugs through a concerted focus on:

- Supply reduction
- Prevention
- Treatment/rehabilitation
- Research.

The treatment pillar has two objectives. These are:

- *To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug free lifestyle*
- *To minimize the harm to those who continue to engage in drug-taking activities that put them at risk.*

(Ireland's National Drug Strategy 2001-2008, p. 11).

The two relevant performance indicators in this regard are:

- 1) To have a range of treatment and rehabilitation options as part of a planned progression programme for each person in each Health Board Region by 2002
- 2) To provide stabilized drug misusers with training and employment opportunities.

In terms of the actions to implement this Strategy it was indicated that training and employment opportunities for drug misusers would be increased by 30% (*“taking on board best practice from the special CE Programme and pilot Labour Inclusion programme”*). Social Economy projects and other forms of vocational training would be developed and reviewed where appropriate with reference to the allocated places within the FAS Community Employment Programme.

3.2 Origins of the FAS role

The First Report in 1996 had outlined a series of recommendations on rehabilitative and reintegration methodologies. These provided the basis for FAS involvement with the issue of training and employment for this specific population.

The summary recommendations were that:

- *More emphasis be placed on providing options for stabilized drugs misusers by way of occupational and social skills training (the Soilse and Saol projects serve as appropriate models in this regard)*
- *Priority status be given to all Community Employment (CE) applications offering work experience/training for recovering addicts that are integrated with other support services*

- *Priority status be given to all CE applications offering work experience/training for former addicts who are employment ready*
- *FAS and LES work closely and establish links with the sponsors of CE projects providing opportunities for former drug addicts who are employment ready, with a view to providing every assistance to the participants to progress to mainstream employment.*

(First Report 1996, p. 15).

These recommendations make it clear that occupational and social skills training were key elements in recovery and reintegration for persons with histories of substance abuse. They also indicate that Community Employment was being identified as the mechanism to develop work experience and training provided that such intervention was:

- (a) integrated with other support services
- (b) directed at *former* addicts who were employment ready.

This formulation reflects international best practice in terms of social and vocational rehabilitation. It however also overestimates the utility of using an existing scheme (Community Employment) to address the multiple needs of people who may not only be far from 'employment ready' but may be experiencing a range of social, economic and psychological pressures associated with their history of addiction. Crucially the recommendation was clearly posited on the need to ensure that such employment oriented interventions had to be integrated with other support services.

High rates of relapse also mean that the traditional time frame for standard vocational training interventions may not always be adhered to. A range of other considerations needs to be acknowledged regarding participation in training programmes. These relate to concerns around social welfare entitlements and

procedures, childcare, medical assistance, counseling and psychological well-being.

The line between rehabilitation and recovery on the one hand and employment directed skill acquisition and training is often a blurred one. In the world of recovery from addiction, however, best international practice shows that participation in the labour market is one of the surest ways to enhance self-esteem and reinforce the process of stability and recovery. A central question exists however at just what point this orientation should be introduced.

This balance between rehabilitation and training has been the core of FAS efforts to meet its objectives under the terms of its involvement in the actions stipulated by the National Drugs Strategy.

In a submission to this Review, the National Drugs Strategy Team summed up this perspective.

In this context, rehabilitation may be described as a facilitative process which aims to enable individuals who are disadvantaged in terms of accessing life in the mainstream to access as independent a life as possible in terms of their health and their social, cultural and economic well-being. In 1997 FAS earmarked 1,000 special Community Employment places to support projects whose aim is to assist drug users to engage in training programmes that assist their rehabilitation while also providing them with training for employment. (NDST Submission 2004).

This view entails a description of client needs based on a progression to independent living. These needs are viewed in terms of short term, medium term and long term – where preparation for work is a long term one. It also specifies a wide range of required supports. Clearly, different individual needs and different individual levels of motivation and ability affect progress.

What is clear is that little if any progress can be made without high levels of professional competence in giving the required supports. While flexibility is essential, significant resources are required to assess these needs and to provide meaningful individual plans to enable the needs to be met and to develop progression for the people concerned.

3.3. Operation of Community Employment

Community Employment is a labour market intervention. It is designed to provide temporary work experience and training for the long term unemployed. Primarily, CE's main purpose is to reintegrate the long-term unemployed into open labour market jobs. CE is the largest active labour market intervention in Ireland.

CE gives the opportunity to acquire work experience and training through part-time employment on community projects. Employment is provided on a wide range of projects which are sponsored by communities. FAS provides the funding for supervisors and participants' payments. The scheme is designed to provide temporary, not ongoing, opportunities for persons over 25 who have been unemployed for a minimum of twelve months.

Community Employment emerged in Ireland at a specific time and place. In that period of the late 1980s long-term unemployment was undermining the employability of many individuals. It was also undermining the capacity of communities themselves to function as cohesive social structures. The widespread alienation experienced by the long-term unemployed often reflected a sense of disempowerment in their communities. Community Employment, ideally, could act as a resource for communities to identify their own needs and priorities in charting viable means of regeneration. This assumed added dimensions as the economic improvements of the 1990s boom changed the context significantly.

Ongoing evaluations of Community Employment have examined the role it plays in an Ireland different from the time of its origin. In 2000, the ESRI found that Community Employment displayed no positive employment effects and stated that:

...programmes with strong linkages to the market are more likely to enhance the employment prospects of their participants than programmes with weak market linkages.
(Indecon, p. 87)

The ESRI Study recommended a gradual reduction in CE numbers, stronger market linkages and targeting opportunities on the disadvantaged.

A study of CE by the Irish National Organization of the Unemployed (INOUE) found that:

With appropriate changes the programme can be significantly improved as a progression measure. This would involve a more integrated approach to participation in terms of career path planning and the development of clear linkages to the labour market.
(Indecon, p. 88)

INOUE recommended funding for core staff to provide services for the disadvantaged, establishment of pre-CE modules for potential participants, closer liaison with employment services personnel and substantial increase in the CE training budget.

The Indecon Report (2002) acknowledged the policy dilemma facing the future operation of CE.

On the negative side, CE is not as effective as other measures at enhancing employability for some participants. Also there is evidence that the relative attractiveness of CE increases the reservation wage of participants and reduces job search activity...Against this, CE provides valuable work experience to participants who may have lost touch with the labour market and helps them gain essential work experience...In addition CE is increasingly acting as a pathway to further education and training.
(Indecon, p. 108).

Among the Indecon recommendations were a greater emphasis on:

- Training
- Job placement
- Work experience
- Liaison with services provided by other agencies
- Consideration of a non-progression CE for those not ready for employment.

In designating 1000 CE places to assist the National Drugs Strategy of assisting individual rehabilitation and training for employment, FAS adapted the general characteristics of existing CE and modified it to meet new and complex needs and expectations.

The results of such an adaptation are inevitably mixed. Much that is positive has been recorded in responses to this Review. On the other hand many contradictory and conflicting elements have equally been reported. Some of these stem from the nature of drug misuse and rehabilitative perspectives. Others pre-date the special designation and are inherent in the aims and objectives of Community Employment itself.

4. Drugs Task Force CE Projects – Structure and Profile

4.1 Project profiles

As an adapted mechanism, Community Employment has played a significant role in the development needs of participants affected by drug abuse and addiction. It has allowed a range of responses to be employed. But the issue of progression, which has become an issue of some stress for projects, highlights a fundamental contradiction at the heart of this scheme. A labour market mechanism is being used to achieve rehabilitative objectives. Frequently these objectives may be at the most rudimentary level. In the absence of other mechanisms the strains and expectations on CE become all too apparent.

In point of fact, Community Employment has been *modified and adapted* to meet the needs of this specific target group. These adaptations include:

- Application and approval procedures were modified
- Age prerequisites were reduced from 25 to 18
- Live register requirement was waived
- Duration of programme was extended from 1 to 3 years
- The participant/supervisor ratio was increased to 7:1
- Increased training and development budgets
- A 25% worker element was included to allow local community workers assist the projects – thus providing training for local people
- Certification to NCVA Level 2 was included and supported.

The vast majority of Community Employment projects with dedicated DTF places are in the Dublin region. Outside Dublin the largest concentration of places is in Cork, although these operate quite differently and will be looked at separately.

Number of Special Projects	
Dublin Central	48
Dublin North	16
Dublin South	15
Cork	10

(See Appendix for full list of projects).

Projects operate generally within community contexts and respond to the needs identified by a variety of community agencies and resources. In responding to the diverse needs of communities, projects themselves display a degree of difference and individuality. This is seen by many as proof of a tailored response to local needs (and indeed individual needs). A degree of standardization is also required to ensure effective operation, conformance with funding regulations and CE administrative regulations.

A noted difference was in relation to the inner city projects in Dublin. Many of these reflected long-standing difficulties in relation to the impact of drugs. Some projects were rooted in activist responses to the issue and many staff were familiar with the issues in depth.

Some schemes were dedicated DTF projects where almost all participants were specially designated as having had substance abuse problems.

In others, there were dedicated places in 'mainstream' CE schemes.

Percentage of dedicated DTF schemes (majority drug users)

Dublin Central	48%
Dublin North	50%
Dublin South	66%
Cork	90%

Some projects pre-dated the development of FAS dedicated CE schemes. Others had been established by the Local DTF and had applied for CE subsequently. Some projects have been mainstreamed, others not. Mechanisms to establish need appeared unsystematic, relying largely on the experience and expertise of individuals and community organizations.

Central to the original concept of Community Employment was the creation of meaningful projects that would meet identified community needs while at the same time providing progression routes to employment or further skill development for participating individuals.

Many Community Employment schemes operate in communities where significant social problems like drug addiction add to the realities of chronic unemployment and underemployment. Schemes have also evolved to provide employment opportunities for project workers who deal with addiction issues and support project activities.

The structure and operation of Community Employment (particularly in the environments of multiple social and economic difficulty) has been a careful balance between the needs and interests of its main stakeholders:

- project sponsors
- employed staff (i.e. supervisors)
- participants.

In addition, the nature of addiction and professional understanding of the dimensions of addiction have changed profoundly in the last decade. Professionals are now aware of deeper levels of difficulty experienced by the client population – not to mention the changing patterns of drug consumption such as multi-drug use, cocaine and crack.

We are coming to realize that an overwhelming number of our young drug users have considerable bio-psychosocial issues to contend with. The multiplicity, severity and chronicity of these problems are seen to create a matrix of disadvantage within which substance misuse plays a part but is not the only issue....The range of interconnected problems this group possess extend outside the specific remits of any of the services they are involved with...Because they have not been provided with the comprehensive and coordinated services that they require, this group often become 'revolving door' clients who wander continually between services.

(Wilson 2000, p. 23)

As of 30 January 2004, there were 812 Drugs Task Force places on the FAS Community Employment scheme.

Gender of participants	
Males	262 (32.3%)
Female	550 (67.7%)

Participant age profile:	
Aged under 30	425 (52,3%)
Aged 30-39	226 (27.8%)
Aged 40-49	94 (11.6%)
Aged 50-59	56 (6.9%)
Aged over 60	11 (1.4%)

In terms of social welfare status on entry to Community Employment, the breakdown for DTF places is as follows

Lone Parents	371 (45.8%)
Unemployment Assistance	169 (20.9%)
Unemployment benefit	63 (7.8%)
Disability Allowance	128 (15.9%)
Disability Benefit	39 (4.9%)
Invalidity or Blind pension	8 (0.1%)
Other	34 (4.2%)

Based on these figures, average costs per participant per day in January 2004 were €37.25 (excluding Supervisor costs) and €44.36 (including Supervisor costs).

While all projects are designed to meet the needs of recovering drug addicts, the nature of both substance abuse and recovery mechanisms varies widely. In Dublin the vast majority of participants are recovering heroin addicts, stabilized on methadone. The culture of heroin addiction and usage has profoundly affected these individuals and their communities. It also poses challenges to supervisors and assistant supervisors in being sensitive to problems or being aware of difficulties being experienced.

While some projects in Dublin have a consistent emphasis on being drug free or stabilized, it is not possible to determine whether participants are using other street drugs. Relapse is frequently mentioned as a concern.

Referral of participants to CE generally comes from clinics, the local DTF, community organizations or individuals themselves. Evidence from respondents is that referrals could be unsystematic with referral sources unaware of the labour market orientation of CE. There is no evidence of systematic prior

assessment set against CE criteria. Participants themselves admit that CE in some cases was unfamiliar and it took some time to become aware of its objectives.

Supervisors play multiple roles in the structure of schemes. Many have developed strong levels of interaction and trust with participants. They frequently facilitate medical, social and personal needs. Counselling and support services vary from area to area. Many participants confirm that CE for them is largely therapeutic and a key element in stabilizing their daily activities.

In many projects much time is spent on group work, confidence building and personal development. Much activity centres on defined needs around literacy, numeracy and basic life skills. Many participants report commencing CE having only recently emerged from periods of profound chaos in their lives.

Many projects have developed extensive educational links and offer comprehensive courses for participants. Much reported progression is to further education and training. Participants report a noted degree of educational activity consisting of courses in addiction studies or related topic programmes.

Many projects are aware of significant issues allied to drug addiction which affect ability to participate on CE. These focus on homelessness and childcare concerns. Much project time both prior to and after commencement on CE can be taken up resolving associated difficulties.

The **training allowance** was reported, by both participants and some supervisors, as a stabilizing factor. The part-time nature of CE makes it attractive to the large proportion of single parents (who expressed concerns about the issue of childcare in pursuing further training). While many participants had some past work experience the experience of addiction has affected morale greatly.

Many are very aware of stigma and feel that full-time employment, without the social and medical supports they require, would be very difficult to attain.

4.2 Cork Schemes

While the vast majority of special CE projects are in Dublin, a number of projects operate outside Dublin – most notably the ten projects in Cork, comprising 110 DTF places.

There are significant differences in the way the Cork projects operate compared to those in Dublin. Unlike Dublin, a majority of the projects do not operate in a community setting but are sponsored by a community enterprise and training centre. Participants, all over 18, are referred through a very structured system. This includes representation from:

- Health Board
- Counselors
- Community support workers
- Garda Siochana
- Prison service
- Women's shelters
- Probation service
- Local addiction treatment service.

Prior to admission to the CE scheme, participants must undertake a structured programme of rehabilitation and are expected to be in recovery. The pre-admission programme runs for three months. Clients are screened and assessed in a comprehensive and standardized manner. Issues around progression are introduced very early and work experience placements and employer linkage is prioritized. The role of FAS is clear and acts a strong coordinating element. FAS motivation and interest is recognized and valued by all stakeholders.

Following commencement on Community Employment, participants undertake a three month continuing programme with the addiction treatment centre and are also expected to attend relevant Alcoholics Anonymous and Narcotics Anonymous meetings in the evenings. Ongoing support is provided by this treatment centre and two half-way homes are also provided for participants. Participants are expected to have made a decision on recovery and each stage is monitored and supported.

Progression is monitored. Since 1998 there have been 850 participants and some 10% have secured open employment. Many are still in employment.

Unlike Dublin, however, the vast majority of participants are not using heroin. Most are using other drugs (primarily marijuana, ecstasy, alcohol, benzodiazepines and increasingly cocaine). All however have an accepted addiction profile whatever the substance. The therapeutic and vocational training dimensions work very closely and in a coordinated manner.

The majority of schemes in Cork are centred in and sponsored by a community enterprise and training centre on the north side of the city which has been operating mainstream CE schemes for a number of years and has a long established track record. Strong emphasis is placed on ensuring that initial referrals are appropriate and meet the stated criteria of the scheme. There is a high level of coordination between the agencies involved. The sponsors are highly motivated and very committed to approaches that prioritize education, progression and employment.

Supervisors reported strong levels of motivation among their client group. Identified gaps were in the stated need for a specialist placement officer, more specific supervisor training and some form of dedicated career guidance resource.

The stated aim of these centre based projects is drug free recovery. An emerging concern is that the majority of participants is female. While they are regarded as very well motivated with a positive focus on further education, there are concerns that men are not availing of the service and that more specific techniques may need to be adopted to reach males.

In Cork there are also a couple of community based projects. While these operate in a somewhat different way, they benefit also from the strong linkages and coordination that has been developed over the years in relation to the role of CE in the drugs area.

4.3 Project Issues

Many individuals with significant drug problems attribute their success in overcoming addiction and progressing to more independent living to participation in designated Community Employment schemes. Many find the opportunity to avail of educational and training interventions. Many experience restored levels of self-esteem and self-worth. Many have the opportunity to develop skills and attitudes to deal with addiction.

Others however feel that the therapeutic and support roles provided were not suitable within Community Employment as currently structured. Many feel that fundamental issues around their addiction could not be addressed in contexts where they were simply unprepared to consider employment - or where the range of social and personal issues mean that consideration of progression to employment is utterly unrealistic.

All the projects reviewed reflect concerns that Community Employment as a scheme is attempting to do too much in meeting both the rehabilitative and

training needs of participants. Issues around progression are seen by many as a real or implied threat.

Key issues emerged in regard to the structure and characteristics of special CE schemes. These centred on:

- **Roles and responsibilities** – sponsors are not uniformly clear of the role and purpose of CE.
- **Assessment** - Clear and standardized assessment and referral systems do not exist.
- **Resources** – multi-sourced resources leads to blurred boundaries. Resources are not uniformly set against clearly defined actions and needs.
- **Participant characteristics** – clients have varying levels of understanding about the nature and purpose of schemes on which they participate.
- **Staff professionalism** – staff training and professionalism vary significantly from project to project. Expertise is variable and professional interventions are not systematic
- **Standards** – projects vary in terms of quality, activities, methods and outcomes. Levels of support and involvement from FAS are variable. Timetables and structured activities vary.
- **Expectations and outcomes** – projects are located in an area between rehabilitation and training for employment outcomes. Different expectations can affect project activities.
- **Drug dependence and addiction issues** - project structures and resource allocation affected in dealing with needs – including crisis interventions.

5. Consultation with Stakeholders

In the interviews, group discussions, project visits, focus group meetings and research which framed this Review, a wide range of responses was given. Respondents were candid and forthright. Most displayed deep levels of concern and commitment that the significant needs existing for individuals (and their communities) needed to be met in the most effective way possible.

The responses are grouped under a number of headings and related to the key sectors interviewed. These sectors are:

- Sponsors and individual project staff
- Project participants
- FAS Community Development Officers

5.1 Sponsors and individual project staff

Projects operate in a number of distinct environments. Sponsors reported that they had been established to meet the needs identified in various settings by communities. These needs related to addiction profiles and associated issues such as childcare, homelessness, imprisonment or poverty. Particularly in Dublin, projects are operated in and by local communities who are attempting to address the problem of drug abuse locally. Some continue previous initiatives (one, for example, originated as an EU NOW project).

Project *sponsors* operate under a number of pressures to ensure not only that projects respond to needs but also that they conform to the regulations and criteria established by FAS for the delivery of Community Employment. Issues around adequate resources and coordinated agency responses are therefore central to the strategic thinking and direction of sponsor efforts.

Many respondents in this Review defined CE as a flexible adaptation of an existing system to meet the special needs of a challenging sector. Sponsors are therefore required not only to identify needs and design effective project responses, but also to ensure over time that these needs still exist or are still being met appropriately. As CE does not meet the full cost of any project, multiple funding sources must also be identified and secured.

Project staff reported a need for strong and dynamic committees that could adopt a professional approach to project development. Many sponsors reported difficulties if stakeholders (examples included Health Boards, VECs, LES) had only occasional or minimal involvement. Trying to ensure a coordinated agency response was a stated difficulty for many sponsors. Many sponsors felt acutely the difficulty in obtaining expertise (for example financial management, counseling, staff training) to develop the levels of professionalism required.

Supervisors are at the frontline of project delivery. Levels of general stated commitment and concern were high. Many acknowledged a lack of training and resources – which was being addressed by FAS as this Review progressed through participation on the Supervisor Development Programme. Coming often from the community themselves, many supervisors are networked and have a good level of insight into community conditions.

Many supervisors demonstrated a confused sense of role clarity in relation to the work undertaken. By the nature of their work, many operated in strong personal support and advocacy roles for participants. Others saw their roles sometimes tending towards addiction recovery support. Many viewed their role as partly therapeutic or as an advocacy one. For some, employment orientation was not a priority as it was felt to be unrealistic for some participants. Others reported what they felt were burdensome levels of administration in regard to meeting FAS requirements, structuring activities or charting progression. Many supervisors,

dealing on a daily basis with the many complex personal issues of participants found difficulty in articulating a vocational or employment perspective in any realistic sense.

5.1.1 Perceptions of FAS

Supervisors and sponsors characterized the role of FAS from often contradictory viewpoints. Some described the role of FAS as “*a necessary evil*”, a mechanism to secure much needed funding. Others saw FAS as extremely helpful and cooperative, providing a reliable and efficient response to issues and concerns. Most respondents felt FAS was not expert in the areas of substance abuse, addiction and rehabilitation. While this was understood, many felt that some specialist expertise within FAS would be useful and beneficial.

There was frequent mention of concerns around bureaucracy and red tape. More mature projects did not find this problematic. Others clearly struggled with what they described as over-detailed monitoring mechanisms. Understanding of the need for standards and administrative consistency was not uniform. Many respondents expressed defensiveness about their record keeping. There was a generally expressed unease about the focus on progression, particularly if understood as securing employment. Some respondents felt FAS was simply being unrealistic in expecting such an outcome from the population concerned. If pressed, many freely acknowledged that the key thrust was rehabilitative and progression had to be recast in other terms.

“For most of our participants, progression means going on to another CE scheme. The main motivation is security and stability and a job just does not enter into it.”

(Scheme supervisor)

Some respondents felt the focus of FAS was too much on control. While concerns around monitoring were expressed, many other respondents found

FAS monitoring beneficial and helpful in giving structure and direction. Some raised issues around the role or practice of individual Community Development Officers. Expressed comments reflected a variation in individual practice by Community Development Officers. While personalities and styles do vary, most project staff placed a strong emphasis on “networking” and could and did compare the various approaches they had experienced.

“FAS is excellent at monitoring regarding finance, administration and developing training plans”.

(Scheme Sponsor)

“Our CDO is firm but very fair. It is a great support - even if the specific drug expertise is not there.”

(Scheme supervisor)

“I would hate to think what would happen if our CDO changed. A new person might not permit the flexibility we have developed. Things can change overnight with a different person.”

(Scheme supervisor)

A variety of perceptions regarding the role of FAS was expressed. This depended on particular projects and levels of involvement. For some project workers and assistant supervisors the role of FAS was vague and not seen as directly relevant to their work. Rehabilitative concerns outweighed labour market progression ones overwhelmingly. Schemes were frequently acknowledged as mechanisms to achieve non-employment related objectives.

5.1.2 Administrative concerns

Regulations and requirements were sometimes described as burdensome, secondary “to meeting real needs”. Beyond meeting funding criteria, administrative standards varied. Record keeping, timetables and records of daily activity could differ. Many supervisory staff spoke about a necessity to meet the vast range of social and personal problems that presented on a daily basis for their clients. For those who saw their role as primarily a caring and supportive one, administrative responsibilities around documented actions and interventions were seen as a distraction.

“A key stumbling block for me is the structure of CE and its criteria. There is a need to educate FAS staff on this issue. We see this every time there is a change in FAS personnel dealing with us. There is a big variation in awareness and interest. FAS seems to display problems with its own internal communications.”

(Scheme supervisor)

There was evidence of some confusion why certain decisions are made in relation to participant numbers or funding approval – again reflecting the networking and comparative communications occurring between different projects. Examples of individual and extremely specific issues were often cited as “evidence” of inconsistency or bias displayed towards different projects

Support and awareness were sometimes mentioned as being absent or undeveloped in relation to FAS. Projects engage with a range of services and agencies and it was difficult to establish what exactly was meant by support or awareness. On the other hand, projects that had strong committees felt they had established good track records in terms of profiles and expertise. Having defined more clearly their roles and capacities they could more successfully negotiate for the supports they needed.

5.1.3 Appropriateness of labour market orientation

This was reported generally as a significant concern. Most responded that meaningful progression to the labour market was not an option for the majority of participants or that, if it were, it could take substantially longer than three years. When asked to state exactly how long such a programme should take to develop job readiness, these respondents mentioned between five and seven years.

Staff reported too many additional problems existed in people's lives for them to realistically contemplate work until they had been addressed. Individuals presented with complex problems and, not infrequently, elements of chaos in their lives. The lack of standardized referral and assessment systems was recognized. This was set against the need to provide some kind of intervention and, in the absence of any alternatives, CE had to fill this role.

"There are so many complex needs – personal, health, family and community. Primarily CE provides an income – that in itself is a stabilizing factor. If the income stops, that is itself de-stabilizing. Since it is a labour market programme, CE does not meet all needs. It is not appropriate for the issues we face."

(Scheme supervisor)

"For many of our participants CE is a destination, not a starting point. A lot of the "progression" is in fact on to other CE projects."

(Scheme sponsor)

The importance of background issues regarding poverty and social deprivation was widely reported as complicating progress towards a labour market orientation. In this regard, a strong emphasis was placed on the role of education as the key lever of change for the individual (and the community). The achievement of certification was frequently mentioned as providing both the best impetus to work and a strong reinforcement of therapeutic aspects.

“We emphasize education and learning from the outset. Most are from really desperate circumstances and multiple problems. There is a strong emphasis on education, learning and actually doing things. Certification is the key to success and nothing can equal the sense of achievement they display when they secure this. Only after that can you meaningfully talk about some kind of work.”

(Scheme supervisor)

“Talk of employment is difficult in an environment of systemic and pervasive poverty and dysfunctional families. Education and personal care plans are the first step – our model aims at personal empowerment. But this will not translate into a job without ongoing support, counseling, training and follow-up. CE is only the first step but we have little to offer in terms of effective follow-up.”

(Scheme supervisor)

The issue of some form of labour market orientation was accepted in responses. However, it was set against the overwhelming priority to establish stability and reduction of drug misuse. In the absence of other measures, many described CE as being stretched to the limit in attempting to meet other needs. In such circumstances labour market orientation was seen, at best, as a distant aspiration or, at worst, something currently unattainable.

For others, progression was seen as any kind of progression –to further education or training or even some form of more active independent social functioning. While this stretched the definitions of labour market outcomes to the limit – it was felt to be the fairest representation of what was actually occurring.

“Outcomes for users are unpredictable. Since CE as we have it is meeting such a huge set of needs, timescales and criteria need to be flexible. There is a need for a safe environment – to get clean needs resources and this has to be recognized.”

(Scheme supervisor)

5.1.4 Rehabilitation or training

This aspect was recognized by all respondents as a central issue in the debate about the usefulness or relevance of Community Employment as currently constituted and delivered in this sector.

Strong opinions were expressed about the Health Boards' lack of consistency or strategic involvement in the area. In consequence, this was seen to leave FAS with an unfair share of the responsibility in meeting the many and complex needs – only some of which were admittedly labour market oriented.

Most respondents saw themselves providing a rehabilitative and support service. The fact that it was officially a training and employment related programme was recognized as contradictory. The responsibility of other agencies, and in particular the relevant Health Boards, to play a meaningful role was constantly raised.

Affected communities are coming under pressure from two sets of contradictory demands. In their communities they face the challenge of helping large numbers of young adults who wish to address their drug misuse problems. Then... through FAS they are faced with the pressure to make their problems more labour market oriented. Neither the rehabilitative nor the labour market modes are mutually exclusive but it is very important to get the balance right... I could honestly conclude that most "special" Community employment programmes see themselves as primarily rehabilitative and that their subsidiary role is to act as a labour market training and employment mechanism.

(Scheme supervisor: Byrne: Submission to Review, 2004).

Many respondents saw themselves rooted in communities, meeting immediate needs and dealing with the complexities of trying to maintain individuals as stable or drug free. The multiple issues facing participants on social and medial fronts underlined this. Many respondents reported considerable periods of time spent in supporting clients, attending clinics dealing with healthcare or childcare issues.

Many saw their roles as facilitative and supporting, up to and including acting in a counseling role.

“We need to tweak the programme we actually offer to meet CE criteria. CE is basically not appropriate but it is a lot better than nothing. Personal development and childcare issues dominate the lives of our clients. Agencies are not well coordinated and we have to pick up the pieces.”
(Scheme supervisor)

“Multiple issues need to be taken into account in planning and delivering interventions. Reintegration and rehabilitation aspects dominate. The lack of childcare is a critical concern.”
(Scheme supervisor)

The importance of training and skill acquisition was acknowledged. While significant variety was displayed between projects, the need for an emphasis on skills and training at some point was uniform.

“The culture of CE in this community is that a CE place is really a job. There is no incentive or desire often to move beyond that. It is hard to develop realistic progression options when clients think they have gone as far as they can go already.”
(Scheme supervisor)

5.1.5 Therapy and guidance

These were mentioned as essential and vital services for people recovering from addiction. Respondents referred to these services as, at best, uneven. Various projects reviewed displayed different approaches to the issue. The specific absence of employment related career guidance was noted by several respondents.

“This project tries to engage with women where they actually are at. It is rooted in community realities and the team works with that.”
(Scheme supervisor)

In environments where support workers come themselves from the community (and sometimes with histories of addiction), it is understandable that roles may become blurred. Many examples of unresponsiveness and insensitivity from official health and medical support services were quoted. Support workers and supervisors often therefore find themselves adopting an advocacy role for clients. This has many beneficial and positive aspects. On the other hand some felt that it deflected from their function as designated under the requirements of CE.

“Staff really need resources and training. It is hard to maintain a focus when there are so many demands on our time.”
(Scheme supervisor)

Much of the time was reported as being spent just trying to *prevent relapse*. Several respondents mentioned this also as a key purpose of CE. In this regard the CE allowance was seen as a stabilizing mechanism to prevent relapse. Relapse rates were mentioned as being quite high. CE was often seen as “holding the line” against relapse or recidivism. Many respondents mentioned the lack of linkage and coordination among frontline agencies in acting to assist the recovery of participants.

“We need substantially more resources from the Health Boards and clinics. There is so little coordination. We cannot do all this on our own and prepare people for work too. These clients are vulnerable and really do get messed around when they try to get support or help. It is natural that they turn to us.”
(Scheme sponsor)

Providing direction in an individual’s life was seen as something very positive within the schemes. Respondents recognized that a labour market focus played the same kind of role in developing motivation that aspiring to drug free status did in the rehabilitative field.

The orientation to eventual employment also provided recognized and valued linkages with non-stigmatizing employment settings. This was articulated most

actively in projects where the educational side was well developed and where certification and acknowledgement of learning were highly valued.

Concerns were expressed about the ability of schemes as currently constituted to meet aspirations –either for employment or to be drug free. Frequently, in fact, CE itself is seen as a destination rather than a stage in a process.

“The biggest addiction around here is the addiction to Community Employment!”

(Scheme supervisor)

5.1.6 Premises and resources

These were mentioned as critical factors in terms of planning and service provision by all respondents. Project staff felt the quality of several projects was adversely affected by the state of the premises involved. Inadequate buildings and lack of space hindered many activities. Many rooms doubled up for other purposes or were shared with other projects or agencies. Office space could be very cramped for some respondents. Others mentioned poor levels of access and limited space.

“Our counselling sessions have to take place in the changing rooms of a gym. It is lacking in any comfort and the smell is awful”

(Scheme supervisor)

5.1.7 Structural complexity

Reference was frequently made to the large number of agencies and regulations in the sector. These included Local Drugs Task Forces, Health Boards, Probation Service, VEC, local authorities and medical personnel (clinics). Staff reported having to negotiate difficult passages through agencies to secure what

they felt they needed. FAS was frequently commended for being clear and responsive, particularly in comparison with other bodies.

Many staff reported significant difficulties trying to negotiate with multiple agencies, often with different functions, roles and interests. The lack of coordination between these agencies was mentioned repeatedly with particular reference to the role of Health Boards. The lack of expertise or awareness in dealing with the realities of addiction was commented upon negatively and frequently.

Allowance and benefit systems displayed their own complexity and, particularly in view of the restrictions in 'mainstream' CE numbers, respondents felt that this aspect had become more uncertain and complicated. Many complained of lack of a coherent direction and plan in developing and providing services such as rehabilitation support, vocational guidance or counselling. In this context, many respondents felt that LDTF resources, however good, were not optimized because of lack of national coordination or direction.

“Our Local DTF is too bogged down in bureaucracy. It is very informal and lacks fresh ideas and an effective structure.”
(Scheme supervisor)

“Inter-agency dialogue is very poor. There should be some kind of national rehabilitative agency with an agreed comprehensive plan, resources and assigned responsibilities.”
(Scheme supervisor)

5.1.8 Learning from others

'Networking' and other links (Citywide) meant that staff can learn from one another. This may be in a way that is informal and unsystematic in terms of making valid comparisons. Nonetheless considerable discussion, comparison and sharing of information was evident from responses at a number of levels.

This can be somewhat unstructured and several instances of inaccurate reporting were mentioned in responses.

Staff did report a need for regular and systematic information and guidance from FAS. Participants on the Supervisory Development Programme mentioned the great benefit of sharing with others through structured training – as well as meeting staff from ‘mainstream’ CE projects.

5.2 Project participants

Responses from participants, by their nature, covered a vast range of experiences, backgrounds and expectations. Individuals were at various stages of their rehabilitative programmes. They also reflected the different environments reviewed – urban and suburban, Dublin and Cork. Certain common themes emerged from all groups.

All acknowledged the comprehensive ***impact of addiction*** on their lives. Many had struggled for years on end to address addiction and problems stemming from often catastrophic levels of disruption and marginalization. Each therapeutic voyage was different. Many were still uncertain about their future potential. Some showed high levels of determination and resolve even if accepting that family and community issues meant their prospects were far from uniformly optimistic. In the wide range of opinions expressed and suggestions offered, the most common themes are recorded.

The most common theme for participant respondents was that, for them, CE was ***rehabilitative rather than job oriented***. Many saw employment as a worthy but essentially remote aspiration. Most were focused on staying stable - with others aiming to become drug free as soon as possible. This would appear to stem from the immediacy of medical and personal needs rather than any rejection of employment outcomes per se.

The high value placed by all respondents on **education and the recognition of certification** attained shows that longer-term perspectives on community and vocational reintegration are not absent. All respondents valued greatly the concept of movement and progression. They displayed strong awareness of and pride in their achievements to date.

All respondents expressed a strong appreciation of the **group support** from other participants. Comments around individual schemes were more varied. FAS, as an agency, was seldom mentioned although its role in the CE scheme was understood.

5.2.1 Escaping the chaos

For most participant respondents this was the most important issue in their participation on CE. All expressed the desire to stay stable and move on to something better in their lives. The very fact of approaching a clinic or agency for help was mentioned as strong evidence of motivation. Some had moved on to CE from clinics in a relatively short space of time. Others took more circuitous routes. For many CE was seen as an end in itself. Several respondents clearly found it difficult to plan beyond the immediate and pressing. Overall, their emphasis was on recovery and improved health. The scheme was valued highly in that regard.

The range of problems expressed was notable. Issues around **money and allowances** were frequently raised. For many respondents (and, on some schemes reviewed, a majority) **homelessness** had been a major factor prior to participation in CE. Self-reporting and the evidence of staff confirmed that the **general health** of participants was very poor. Diet was often inadequate and the general well-being of participants was not ideal. Hygiene standards could be very low. Knowledge about self-care and health maintenance could be rudimentary in

the extreme. Many projects were valued and esteemed for addressing these issues directly.

Many respondents expressed concern about the ability to stay clear and ***avoid relapse***. This was particularly marked in inner city projects in Dublin. The specific nature of the schemes in Cork meant that this was not expressed to the same extent - respondents there felt they had comprehensive and well-structured supports in place to address their dependency concerns. For several respondents in Dublin, great uncertainty and even fear was expressed about the half-days when they were not participating on CE. Some even confined themselves to home to avoid the danger of contact with environments that might lead to relapse.

5.2.2 Self-esteem and confidence

One of the most consistently valued elements in CE participation reported by respondents was the growth in levels of ***personal self-esteem and confidence***. Many expressed delight at their ability to make some progress in a very short time. Particularly with regard to educational activities, respondents found participation to be of benefit. The mere fact of having something structured to do on a daily basis was hugely significant for many. The ability to see progress and to be valued for achieving progress had a positive impact.

Many, especially women, came from backgrounds of abuse and devaluation by others. Being able to achieve things for the first time led to correspondingly higher levels of pride and satisfaction. This was by no means consistent. A noted feature was the variation in levels of participants (in terms of recovery, ability and motivation). Many reported that prior to participation in structured schemes they had very low levels of self-esteem.

5.2.3 Educational issues

Participants and staff confirmed significant ***problems with literacy*** and basic educational competencies for a majority of participants. Most lacked any formal educational attainments. Most left school early. Few had participated in any formal educational activity since leaving school. Most participants responded very positively to the educational programmes on offer in the schemes reviewed. Some had done exceptionally well and had gone on to do further courses. Some projects had been able to follow up the educational progress of participants and the results were impressive and positive.

All respondents found this an important way to secure advances in their lives. Educational attainments also acted as a positive reinforcement for new entrants into schemes. There was evidence of those who succeeded acting as positive role models for others. On some projects many further educational efforts entailed doing addiction studies or deciding to pursue a career in drug support work.

Certification was a generally valued outcome of such education (and training) activities. Some projects had put special effort into arranging awards events and this had a positive and beneficial effect for participants and their families. The desire to learn and secure recognition for this learning was evident in all responses from participants and accords with international evidence on the importance of such elements.

5.2.4 Recognition

Participants were acutely aware of a social labeling process that viewed them as merely addicts. Many had additional issues around depression, psychiatric disorders, imprisonment histories and long periods of simple inability to cope.

There was a strongly expressed desire to be viewed as something other than a “junkie” or “addict”.

Addressing *stigma* was a frequent concern for participants. While CE was seen to help to some extent, the fact that they were on special or designated schemes was noted. In this regard, several participants expressed unease at staff not being adequately trained or skilled to respect issues of confidentiality especially when they often might come from the same community. Several participants, in this context, expressed concerns about the need for professionalism. In all special CE schemes there is a rehabilitative component - participants were anxious that this be as discreet and confidential as possible. This is a common factor in all responses but its extent and nature varied from one project to another.

5.2.5 Future prospects

As both individuals and in focus groups, participants described their future prospects first and foremost in terms of *health and maintaining such addiction free status* as they could. Any future development depended on this. Many were grateful that CE had given them the first opportunity to formulate future plans and to think realistically about progression. Some projects addressed the question of progression very early on and participants had very clear ideas of what was expected or possible. In other projects, however, expectations were not so clear to participants who saw CE largely as an action to support their recovery or as a means to provide some financial stability and activity in their lives.

Some participants felt there was a lack of specific vocational guidance that took into account the range of issues presented by substance abuse and addiction. Others valued greatly the personal achievements during their time on CE which they saw extending to their personal and family lives (although not necessarily by securing full time employment). Many simply conceded that full time employment

was not an option for them “at this point”. The realism of employment outcomes was not so much questioned as their personal ability to rise above the financial or childcare issues that dominated their days. Getting adequate training was accepted as having great benefits for personal development. Translating this into a job was regarded by participants as something different.

Many privately expressed grave reservations whether they would be up to the demands of a job for a long time to come. When asked what kind of time would be needed, participants (and some supervisors) talked about anything up to several years. Although some reference to employer attitudes was made, the key expressed factor was that addiction is not an easy process and a lot of time was needed before recovery could be achieved.

“Recovery is a process, not an event”.

(Scheme participant)

It is noteworthy that several participant respondents described progression as movement towards some form of **drug free status** and not towards employment.

5.2.6 Childcare

Research confirms that while people with drug problems are predominantly male, it is mostly women who seek treatment. The regulations governing CE give a marginal benefit to female participants and are cited as a factor in the preponderance of women on the schemes. Within this general picture are many other complex regulations that act as a strong deterrent to discontinuation of benefits and transition to work. Many participants reported significant difficulties with regard to housing allowances and entitlements which produced real insecurity and instability.

The fact that the majority of participants are women and that many of these have sole responsibility for childcare (often themselves being single parents) has a significant and profound impact on how they view participation on the CE scheme. Time and again respondents mentioned the complex and pressing difficulties of trying to arrange adequate childcare and to balance the demands of training, drug abuse recovery and family responsibilities.

In some projects it was a major concern and affected most aspects of participants' lives and activities. The patchwork nature of childcare provision meant that many women could not contemplate any form of activity (either rehabilitative or training) without adequate childcare supports being in place. One of the highly valued aspects of participation in CE schemes was the provision of a supportive nurturing environment where there was structure and order to daily events. When childcare was present this operated much more smoothly and participants could concentrate on their own needs.

The inadequacy and lack of uniformity in childcare provision (both on schemes and in the community) was one of the most consistent elements in feedback from participants.

5.2.7 Independent living

In both individual and group discussions, participants were honest and forthright about the chaos in their lives caused by drug abuse. For many this was not simply a story of their individual experience but the story of their family members' encounter with addiction – partners, siblings, children and parents. Many were open about their early school-leaving and fragmented work histories. Almost all spoke with conviction about the determination and motivation required to take the first step away from addiction and lives dominated by drug misuse.

It was also clear from responses that this was neither an easy nor a smooth process. While clinical experiences varied, many felt that adequate support and counseling was not always provided. There were significant differences between individual experiences, Most had concerns about their personal fragility and genuine fears around relapse. Many in the Dublin area had contradictory feelings about the role of methadone in their programmes. All had concerns about the lack of structure if something like CE did not exist and how this could lead to relapse.

Many spoke forcefully about their sense of ***lack of coordination in health service provision***. Participation on CE schemes was valued for providing activity and support on a number of levels. Apart from the financial benefit (which for some was real and a decided incentive) participation offered a process of therapeutic engagement. For many there were associated issues around personal health, personal loss and bereavement. For many a sense of hope and possibility was present in their lives for the first time in years. The single most consistent positive response was the growth in levels of self-esteem and confidence – usually associated with educational attainments.

The ***social contexts of participation*** in CE are paramount for most participants. Peer group opinions, family circumstances, community attitudes and the supportive role of project workers and supervisors all feed into this context.

Transition to employment is another matter. On this topic participants were aware but not at all consistent that this would be the outcome for them. More emphasis was placed on health maintenance and an ultimately drug free status. Many spoke of the longer-term perspective in terms of independent living of which employment would only be one element.

5.3 FAS and Community Development Officers

FAS personnel, at all levels interviewed, have long experience of the operation of CE and have been centrally involved in the adaptation of the scheme to meet the needs of drug misusers and those in recovery. As such, many respondents were able to link their comments on the operation of the “special places” to a wider critique of the operation and function of Community Employment itself in labour market preparation.

Many respondents had extensive dealings with individual projects. They were intimately familiar with the dynamics of participation and the difficult environments in which projects often operate. While significant differences exist between the Dublin and Cork projects, there were common concerns and insights from respondents. Some, but not all, Community Development Officers were also members of Local Drugs Task Forces. Some, but not all, had taken a particular interest in the drugs issue and were familiar with the significant issues and lines of debate in the recovery, rehabilitative and employment perspectives.

Almost all FAS respondents expressed concern about the appropriateness of FAS involvement because of:

- (a) its own lack of specialized drugs expertise
- (b) the absence or lack of involvement of other key players and, in particular, the Health Boards.

Many drew parallels with the issues around disability and its specialized structures. Responses did not generally indicate a reluctance to be involved as much as an awareness that what FAS did best (prepare for labour market entry) had to be focused on a comprehensive multi-agency strategy with appropriate therapeutic and rehabilitative supports supplied as and when required.

Almost all responses expressed concern at the level of structure and clarity in the operation many special CE projects. Many projects were described as too loose and unstructured with demonstrably poor levels of role clarity in functional terms. Progression was generally felt to be problematic. It was acknowledged that when adequate resources and linkages were established progression, especially within educational contexts, could be significant and positive.

Almost all respondents felt that the pressing needs of the client group should be met by a more well-structured, resourced and efficient programme - of which the CE component would only be a part. Most agreed that **balance** was necessary in the interventions provided. Too little emphasis on labour market progression would only produce a cycle of dependence and minimal recovery support with no longer-term focus. Too much emphasis on labour market outcomes would intimidate and demoralize a vulnerable population at frequently fragile levels of recovery.

A general concern expressed was the **lack of standardization and practice**. Projects varied greatly not only in terms of outcomes (which were felt to be inadequately monitored anyway) but also in terms of process and operation. Particular concerns were expressed by most respondents around assessment criteria, identification of needs and the structure of activities to meet these needs. There was a concern that FAS resources were called upon to meet a range of social, personal and economic needs for which it had neither the expertise nor resources.

5.3.1 Variation in schemes

Most respondents stated that there was significant variation in the operation of many CE schemes. It was difficult to compare like with like because of the lack of standardization. Most felt this went beyond local particularities to the point where

it was difficult to compare outcomes – particularly if set against progression criteria. Many were aware that the expectation for many participants would be movement to another CE scheme. Other projects were very well structured and had achieved excellent outcomes.

Particular concerns were expressed about poor referral systems. Criteria for acceptance were frequently very unclear. While projects could and did communicate through various networking channels, there was a perceived need for standardization in the development of projects set against some form of quality standard that could produce benefit for all stakeholders.

Procedures could vary widely on a number of levels. Process mechanisms were frequently unclear.

“The criteria for assessment and acceptance of applicants are not always clear – they need to be related to labour market outcomes. Participants need to show that they have some chance, however small, for success in open labour market progression.”

(FAS staff)

“Referral systems are not consistent for participants. It can really vary widely. This extends to procedures to assess or monitor drug use. There is a big variation in approach.”

(FAS staff)

“There is a need for tighter and less open recruitment mechanisms. There is also a need for better and standard client profile specifications.”

(FAS staff)

“Assessment and screening procedures need significant improvement.”

(FAS staff)

5.3.2 Appropriateness of CE for target group

Almost all respondents felt that, at best, a small minority of participants had any realistic chance of labour market progression. Most respondents stated bluntly that Community Employment was the wrong mechanism to achieve meaningful outcomes for the population concerned. It was felt that CE had been stretched to its limit and covered a multitude of rehabilitative aspects without necessarily addressing any employment aspects.

This was seen as having a set of implications for the role of FAS.

“CE is just the wrong vehicle. Apart from that it means our role (FAS) is unclear and we operate with a very confused brief”.

(FAS staff)

“I have a serious doubt whether FAS should be running these programmes at all. The guidelines are generous – including a fast-track system into schemes – and modifications have been made to adapt to needs. But the needs are extensive and complex. Engaging in CE means that there is a need to show participants have some chance of success in progressing to employment at some point and many simply do not.”

(FAS staff)

“By default, CE has ended up at the front end of what can be a lengthy rehabilitation process. This was not the original idea. CE should be employed after treatment (either drug free or stabilized). CE is thus expected to deliver what it cannot at that stage of the process. It turns into a maintenance programme rather than a step to something else.”

(FAS staff)

5.3.3 Issues on standards

Respondents felt standards varied greatly. While administrative mechanisms could ensure administrative regularity, a quantum leap in quality was required for many projects in the view of many FAS respondents. It was recognized that projects worked in difficult circumstances and tried to meet many needs.

Nonetheless issues around perceived lack of transparency, lack of role clarity and poor levels of professionalism worried many.

“Too many programmes are put together loosely and are not set against outcomes. They simply do not fit the labour market.”
(FAS staff)

“Many see CE as just a funding vehicle and do not appreciate that it has its own dynamic. There is a real reluctance among some to accept external monitoring or accountability. FAS has shown flexibility but we need transparency in operation and process.”
(FAS staff)

“There is no common standard and sometimes no clear demarcation between FAS and the sponsor. Roles are unclear and many projects seem to have a life of their own. There is a lot of overlap and often little transparency.”
(FAS staff)

“Sponsors need to be committed to what they are being funded for and demonstrably committed to making a real difference.”
(FAS staff)

5.3.4 Developing project capacity

Respondents felt that more training was needed for project staff. Core staff were often unclear about their own roles. A significant investment in capacity building was required. Specific job planning modules were recommended strongly. The lack of vocational or career guidance in projects was noted.

Many respondents felt that project committees and sponsors would be strengthened through receiving specific training. This would foster businesslike and professional approaches.

“There should be a job description and person specification for each CE supervisory post. There need to be standards and comprehensive training for staff operating special CE schemes.”

(FAS staff)

“Effective tracking systems are needed with criteria for acceptance related to labour market conditions.”

(FAS staff)

There is a strong need for effective interagency partnerships. An integrated State agency response guarantees success.

(FAS staff)

“I recommend all assistant supervisors of drug task force approved schemes are encouraged to undergo an intensive period of training using the Jobplan model. (This intensive programme has identified a disparity in providing CE as an appropriate model for assisting recovering addicts. Participants stated that returning to a project where support, understanding and a knowledge of their needs is poor and the level of expertise is weak is unhelpful).”

(FAS staff)

5.3.5 Resources and skills

Respondents generally referred to the perception that FAS staff lack the expertise for effective involvement in this area. Some felt the entire field should be left to experts. Others felt that FAS staff should receive specific training or supports.

“FAS staff need briefing and preparation for work in this area. A clear policy needs to be in place regarding the role of FAS”.

(FAS staff)

“FAS staff involved in this field need a forum to exchange experiences and issues. At present there are no training or resources.”

(FAS staff)

“There should be rotation of FAS staff to avoid burnout”.

(FAS staff)

5.3.6 External linkage

Recurring comments referred to the need for strong agency coordination and cooperation to ensure that the resources involved in CE as applied to this sector were used most effectively. There was a shared concern in many of the comments from FAS personnel that FAS had committed a substantial resource which was now expected to cover too many issues.

There was an additional concern that other bodies had not committed an equal share of resources or expertise. In particular, concerns expressed referred to the lack of systematic Health Board involvement or allocated resources. Responses were felt to be fragmented and often ad hoc.

It was generally agreed that substantial effort needed to be put in to a rehabilitative and assessment phase prior to client referral for CE (much as has happened in Cork). It was appreciated that too much responsibility was left with often under-funded and under-resourced local committees. While these had good local knowledge, the expertise and professionalism required should come more appropriately from the Health Boards.

5.4 External views

As part of this Review the insights and perspectives of a few key external agencies were sought. Many individual respondents were members of Local Drugs Task Forces or other bodies. The scope and nature of the Review meant that it was not feasible to conduct a systematic analysis of the opinions and perceptions of all external stakeholders involved in the specially designated Community Employment scheme process.

Valuable comment was received from a number of individuals and groups. While none of these should be regarded as official positions, the insights and suggestions are informative.

The ***Northern Area Health Board*** has played a prominent role in advancing a comprehensive position on the rehabilitative needs of individuals and communities affected by drug abuse. Operating over five Local Drugs Task Force Areas, the Board has taken a unique and proactive route in relation to addiction issues in the Eastern region. In addition, it is responsible for the only Health Board drugs project in the region, Soilse. This project has been evaluated separately by the MDRU and advanced as a model of best practice. The Health Board also operates a number of short programmes in specific areas in association with bodies like the LES and VEC. These are of limited scale for particular groups and are designed to meet specifically local needs.

This Health Board accepts that CE may only be suitable for a small minority of people with substance abuse and addiction problems. Its stated vision is based on a vocational rehabilitation model. In this people need to be seen over a spectrum of life experiences, skills and aptitudes. Progression is critical and progression is understood as movement away from problematic drug use.

Personnel described a huge and confusing mix of models in the rehabilitation field. Individuals are felt to need a subtle and graduated set of stages in their recovery - of which employment related interventions were only a part. The reality is that a large proportion of participants on CE will simply never make open employment. In this case, there will probably have to be provision for some form of supported or sheltered employment. There is a demonstrated need for some type of structured interagency project. FAS is seen as being able to supply the expertise on training and employment.

Soilse personnel stressed the need for a holistic and community focus where standards and professionalism are emphasized. Referral and assessment processes were critical. Their experience was that clients need ongoing development, a defined change in the process of life and work along a multi-agency, integrated development continuum. In effect this is Care Planning from stabilization to drug free. This approach has given over 200 drug free participants for Soilse over the past five years.

Concerns were expressed around the continuing dominance of medical models. The weakness of research and feedback mechanisms was mentioned. Coordinated regional and national plans were essential, involving all stakeholders. Soilse felt a working knowledge of addiction must set the value chain or otherwise agencies would become enmeshed in chaos.

The ***Misuse of Drugs Research Unit*** has devoted extensive resources to reviewing the changing nature of the drug abuse scene and the impact of addiction issues in this context. The MDRU has concerns about the impact of the overuse of methadone and benzodiazepines in the longer term. It shares the perception of Community Employment as a scheme that can only meet the needs of the minority who can move on.

Evidence from its research shows that State policies can often be reactive in relation to drug use. There is a need for a wide range of activities with a particular emphasis on education in community contexts. Its work shows that State agencies can play a critical role in teaching and training communities to deal with the consequences of drug abuse. The FAS expertise was viewed as most appropriately applied at the end of a rehabilitative process when clients were recovering and prepared to consider some form of employment.

The evaluations carried out by the MDRU included reviews of the work of agencies like SAOL and Soilse together with newer projects like Business in the Community (with its direct link to employers under the theme of Corporate Social Responsibility and its linkage to the Probation Service).

5.5 Specific Recommendations

POLICY LEVEL

- 1) It is recommended that only projects that have a rehabilitative as well as a labour market focus should be supported by FÁS. This means that a parallel set of rehabilitative support services (such as counseling and health related services) would operate in tandem with FÁS provision.
- 2) Such integrated projects should draw up annual or bi-annual plans that reflect the resources and supports from all funding agencies and be tracked and monitored in terms of these inputs and agreed outcomes.
- 3) All staff working on such projects should receive specialized inputs in order to understand and support the needs of this client group.
- 4) It is recommended that an appropriate assessment system be implemented for all persons prior to scheme referral. Assessment criteria should be in line with the goals and objectives of CE and corresponding rehabilitative needs that can be met concurrently.
- 5) An effective referral system needs to be put in place to ensure that all potential referrals receive adequate assessment and are referred to the scheme or programme that best meets their needs.
- 6) An integrated follow-up support service for persons exiting schemes needs to be put in place for participants to ensure a positive transition from the programme.

- 7) In the case of relapse, provision should be made for ease of re-engagement into programmes and rehabilitative services.
- 8) In view of the disproportionately high percentage of early school leavers with extensive education and training needs on DTF CE schemes, additional educational resources are required with a focus on providing educational programmes for participants.

OPERATIONAL LEVEL

- 9) The range of problems faced by participants must be acknowledged. While much useful work is being achieved, it is not necessarily linear and rates of relapse are significant. CE is neither designed nor resourced to meet this full range of rehabilitative needs. CE participants with addiction profiles need access to rehabilitative supports and services that should be provided by appropriate health authorities.
- 10) Schemes should have some system to enable greater focus on drug-free, stabilized or other designated categories and should have corresponding resources for operation.
- 11) Greater clarity about the role and function of the Rehabilitation Committee that is supposed to operate in each LDTF area is required.
- 12) Allowances are complex and frequently the only means of support for a vulnerable and marginalized population. Recent modifications to accommodation allowances require examination to ensure clients can remain on schemes.

- 13) There should be a clear distinction between the labour market provision on schemes and rehabilitative provision. It is recommended that these are two separate and distinct elements.
- 14) Greater emphasis on training for employment planning and job seeking needs to be provided. Dedicated employment modules should be provided on each scheme.
- 15) Evidence from earlier evaluations is that labour market outcomes are more successful when clients are filtered or “cherry picked”. The implications of this would include a degree of fine-tuning of projects so that different schemes could respond to different identified needs. In the absence of other such schemes, CE currently absorbs the full range of expectations.
- 16) Appropriate sheltered or long-term supports for those not suitable for labour market progression are required.

6. CE Projects –Themes and Processes

6.1 Themes

From all the responses received during this Review process, all contributors repeat certain themes.

- All accepted that the time had come to review the operation and direction of currently existing schemes.
- All also agreed that the scheme had originated as an immediate response to identified need and did so by adapting a pre-existing programme which had a different and distinctive origin and direction
- Many contributions also stressed the need for more formal evaluative and research resources to be devoted to the sector. This was seen as having particular relevance for fine-tuning methodologies responding to individual needs as well as structuring more effectively (and efficiently) programme responses.

6.2 Impact of changing addiction scene on service provision

There was an appreciation of the need to develop a comprehensive overview of the role and impact of drug abuse and the impact of addiction in Irish society. Many respondents were concerned that policy responses were all too often reactive. Evidence of trends shows that significant change is occurring in the pattern of drug use, the type of drugs being used and the social profile of users. Frequent reference was made, for example, to the increased use of cocaine, the effect this was having and the fact that cocaine abuse is not susceptible to the drug-substitution strategy that has been used in relation to heroin.

Methadone treatment itself raised many issues and concerns for respondents. This highlighted the fact that it, like many other strategies, cannot be adopted in isolation and without reference to other mechanisms, interventions and supports.

6.3 Lack of inter-agency approach

A key theme emerging from this was the perceived sense of a lack of a coordinated plan with all agencies acting in concert. Many respondents referred to partnership approaches existing only in theory. In reality many strategies were seen to be driven by only a few agencies. In the area of CE schemes this largely meant FAS. It was felt that any integrated approach must involve systematic and defined inter-agency intervention as, without this, there will be no chance to implement meaningful role clarity.

6.4 Organizational confusion

Many respondents referenced what for them were extraordinary levels of organizational complexity. Reference was made to overlapping schemes, complex interagency relationships, labyrinthine funding mechanisms and regional variations. Participants experience this sense of organizational complexity in a very different way. There was consistent evidence of confusion and disempowerment in regard to information and advice in making choices.

6.5 FAS quality assurance for schemes

Reporting relationships were frequently described as vague or confusing. For many respondents there was little systematic awareness of the FAS role beyond the purely administrative. Counselling and support services vary widely from project to project. There is little evidence that medical referral sources, for example, are aware of the labour market orientation of CE, instead often seeing it as a rehabilitative mechanism which is locally available.

The administrative role of FAS has been developed clearly. There is not the same clarity regarding the FAS role in qualitatively supporting or influencing project development. It was noted that some CDOs, for example, are members of the LDTF while others are not.

The nature and structure of **referral systems** to schemes was a common theme – sources and mechanisms vary greatly. Reasons for referral also seem to be varied. There was frequent mention of lack of clarity regarding expectations from CE participation. Evidence exists of referrals ranging from formal and informed to extremely informal. One supervisor stated for example that he could use an “instinctive sense” to determine someone’s suitability for the programme. Significant variation exists on information required for admission, on the degree of confidentiality expected or offered and the mechanism used.

The need for a clear referral system to schemes by DTFs and rehabilitative centres was expressed.

Assessment mechanisms for CE participation vary from project to project in unsystematic ways. The criteria for assessment were infrequently set against labour market outcomes. Assessment is a critical issue in determining that needs are set against the resources, aims and objectives of any particular scheme or project. Most respondents confirmed that this was done in an at times random fashion. Some projects had developed improved assessment mechanisms. There is little evidence of standardization or whether assessment criteria are set against needs that should be detailed in a Personal Care Plan.

The same would apply to **entry criteria** for projects. Many participants were referred after periods of substantial chaos and distress in their lives. Flexible entry criteria are appropriate for rehabilitative programmes where needs are immediate and a process is commencing. Such flexibility can impact on vocationally oriented programmes in a different way. Following from this would

be evidence of different ground rules in project operation (including drug use). Attendance for medical care, relapse and purchase of drugs were all examples given of reported issues where regulations could vary.

The operation and management of projects varied significantly in terms of structure and professionalism. Physical facilities could be extremely inadequate. In view of the exceptional and complex needs of many participants, it was critical that staff qualifications and expertise were standardized and of a uniformly high level. This was not always the case. Support services were not uniform, Significant efforts were made to develop and enhance community linkage. This was problematic for some projects because of available resources. The need for creativity and innovation was recognized for successful operation of projects. This called for good levels of commitment and professionalism sponsors and staff alike.

6.6 Role of schemes: client expectations

Client expectations varied significantly in all responses received. Most stated that some form of employment is distant. Independent living is a highly valued outcome. Insofar as employment could facilitate this, it would be valued. For almost all, however, the most pressing need was staying away from drugs and drug related environments, maintaining health and re-building levels of confidence and self-esteem.

Individuals had many and complex personal and family issues. Any scheme that offered structured social contact, personal development and a steady if moderate income was to be welcomed. Most admitted that employment was not a priority. In view of the health issues present for most participants (particularly on entry to a project) this is understandable. Again, while the rehabilitative element is foremost, this does necessarily rule out a labour market orientation at some future point.

A key theme was the understanding of **progression** and what it meant. A wide variety of understandings and definitions were in operation. This range is so wide as to make any meaningful comparison impossible. Some saw progression as any development that improved any aspect of a participant's life. Others saw progression in medical, social, familial or substance-free terms.

The fact that so many respondents reported progression as an expectation to secure entry to another CE-type scheme is noteworthy.

This raises the issue of alternative programmes structured along sheltered lines to provide the supports required. **Stabilization and development** are steps along a progression path. Educational progression was highly valued. Progression to employment has specific contours and a more specifically vocational element was acknowledged as key to this.

Many respondents freely accept the majority of their work is primarily rehabilitative. Approaches to employment were recognized as in need of development. More work experience placements, more direct employer involvement, more specific employment seeking skills - these were issues that many projects in Dublin (although not in Cork) had been unable to develop systematically.

It was generally recognized that the CE projects under review were attempting to balance rehabilitation, vocational training and labour market orientations. This was not being done in a standard way in all cases. In such circumstances respondents agreed that clear policy goals would provide the best outcomes for all stakeholders.

Key Learning Points

The themes emerging can be looked at under a number of aspects. These relate to:

- Policy level
- Inter-agency input level
- Scheme operation level
- Participant needs level
- Evaluation mechanism level.

7. Conclusions

7.1 Best practice

International and national experience shows the impact of drug misuse on individuals and communities is complex. Stigma, hopelessness and marginalization add powerfully to the effects of addiction. High levels of relapse and recidivism complicate recovery and reintegration strategies. Addiction is a complex psychosocial issue with direct linkage to family, community and peer group aspects. No single model of recovery and reintegration can suit all.

While international evidence shows integration on a training scheme and a focus on employment have tangible benefits, the issue is one of timing and sequencing within the recovery process to ensure successful outcomes.

Community and voluntary groups have been operating drug rehabilitation projects for a number of years now. They have generally found CE to be a useful support. Nonetheless the differences entailed in rehabilitative and employment oriented approaches must be balanced to meet individual needs. Both aspects benefit from enhanced professionalism, standardization and quality. Clarity in regards to objectives leads to clarity in terms of outcome.

Communities often rely on CE because there is simply no other mechanism or resource to develop interventions.

“CE is not appropriate for the needs here, but it is better than nothing.”

(Scheme supervisor)

Key Conclusions – Best Practice

- Community and Voluntary sector expertise has developed with use of CE.
- CE schemes display a tension between rehabilitative and training dimensions. This can lead to neither set of objectives being fully achieved in relation to the client or the scheme.
- FÁS CE Schemes have funded employment opportunities in communities. There is a risk of vested interest in maintaining them for this purpose rather than because they meet the employment needs of participants.
- Schemes do not consistently demonstrate transparent and businesslike procedures and practices regarding employment objectives for clients.
- Clearly defined objectives, operational standards and methodologies are not standard for all schemes.
- As capacity building is central to the longer-term impact of projects, standardized staff training and development is a critical issue in terms of both rehabilitative and labour market remits.
- Standardized approaches are not present for projects in relation to activities, timetables and certification mechanisms. There is a lack of structure in the operation of some schemes.

7.2 Inter-agency focus

Independent evaluations have shown CE in general to be an expensive programme to operate and should be reserved for the most disadvantaged clients. In relation to drug misuse, the **original brief** for CE was to focus on:

- *Occupational and social skills for recovering addicts*
- *Operate in Integration with other support services*
- *Targeting former addicts who are employment ready.*

It is the conclusion of this Review that CE only makes sense if delivered as part of a coherent and interlinked programme of rehabilitation and support for this client group.

A vulnerable population with varied and significant needs relies on inputs often delivered solely through CE. The needs of this population are extensive and pressing. Specific burdens regarding childcare, allowances, housing, health and imprisonment complicate personal goal setting. Many clients are exceptionally marginalized and disempowered with profound feelings of worthlessness and exclusion. Personal care plans are needed for individual advance. This is by nature multi-agency.

A comprehensive rehabilitation service is essential so those exiting CE do not simply go back to where they were before they started. Rehabilitative intervention is a Health Board responsibility, not one for FAS.

Key Conclusions – Inter-agency Focus

- There is an absence of complementary contribution from health, education and rehabilitative agencies.
- There is a lack of integrated approach to resourcing projects where health agency involvement is present in addition to FÁS.
- Monitoring, support and tracking need to be coordinated by all agencies.
- Many additional supports are required in terms of counseling, education, training and recovery. Person centred strategies need to be enhanced by family supports. This is not being done consistently.
- There is a gap in overall management in the provision of coherent and interconnected services critical to an effective interagency response.
- A key role remains to be played by the Health Boards for the provision of counseling, long-term supports, treatment interventions and appropriate rehabilitation support models.

7.3 Outcomes for Participants

Significant benefit is achieved in CE schemes in relation to participant needs in a variety of areas. These include health, stabilization, social contact, growth in personal confidence and a renewed focus on improved learning skills. There are therapeutic and rehabilitative benefits from such schemes.

The central contradiction remains that these benefits emerge from a labour market progression mechanism that has been substantially modified from its original objectives.

Respondents frequently referred to outcomes that were intangible or not susceptible to quantification, these differed from the progression outcomes set down by FÁS which were employment related. Progression was frequently described in such a broad way to make it almost meaningless as a concept.

Key conclusions - Participants

- CE makes a valuable contribution to participants' stabilization and social development – particularly educational development
- CE is the main vehicle of response, and sometimes the only response, to the rehabilitative needs of clients
- Educational/training attainments and adult education methodologies have been shown to be highly successful in promoting recovery, skills and progression.
- Two-thirds of participants are female and almost half (46%) are lone parents. Childcare provision is an issue.
- Employment Progression is not seen as a realistic option by many participants

7.4 Operational issues

Several project staff displayed lack of clarity about their key objectives. Many reflected real tensions in adapting what they did to requirements for securing and maintaining funding. Many stated they were running beneficial support programmes which, however, simply did not conform to the stated criteria of progression and employment. This was because of the range of social and personal problems in the target group.

Referral procedures vary widely from informal to more formal mechanisms. There was an admitted lack of standardization in initial assessment of suitability. The consequence of this was an inability to clearly define needs and match them to the services on offer in individual projects.

Key conclusions – Operation of Schemes

- There is inadequate structure and framework for the operation of schemes
- Referral systems are often ad hoc and unsystematic.
- There is no comprehensive assessment of individual needs prior to CE.
- There is no consistent policy on participants being drug free or stabilized prior to scheme commencement.
- There is great variation in scheme provision and operation – expected outputs vary.
- CE supervisors often provide therapeutic and rehabilitation inputs.
- Staff training and professionalism vary significantly from project to project.
- There is insufficient appraisal and follow up of outcomes of schemes.
- There are gaps in service supports (childcare, accommodation, guidance, facilities).
- Funding and resources are not uniformly adequate to meet all the training, guidance, vocational and support needs required for a viable employment orientation.
- Many projects lack adequate premises and resources.

8. General Recommendations

POLICY LEVEL

- 1) FÁS and the National Drugs Strategy Team should re-position this intervention in line with the original policy of the *Ministerial Task Force* (1996) which was (a) to be integrated with other support services and (b) directed at *former or stabilized* addicts who were employment ready.
- 2) It is recommended that an Integrated Management Committee is put in place - representative of Health, Education and FÁS - to oversee the provision of integrated rehabilitative services required by former or stabilized drug-misusers.

OPERATIONAL LEVEL

- 3) Currently functioning CE projects should not be replaced without well-resourced alternatives in place. Any successes of special CE projects should be subsumed into labour market perspectives as an essential part of longer-term rehabilitative initiatives.
- 4) Participation in a “pre CE” programme would be beneficial for potential clients.
- 5) FAS should seek to ensure that sponsors secure staff that are qualified and experienced.
- 6) Vocational training and guidance and job awareness modules should be introduced from the outset in all schemes.

- 7) Levels of vocational guidance vary – if present at all. Participants define this as a key need.
- 8) CE plays an important role in allowing participants to move from specific drug related projects to wider mainstream options. This should be part of an exit/progression strategy.
- 9) FÁS staff involved with management of these schemes requires special knowledge and competences.
- 10) Staff rotation is a consideration for both FÁS staff and CE staff. There is evidence of burn-out and a degree of isolation for scheme personnel.
- 11) There should be clear client profile specifications for all schemes.

STRUCTURAL LEVEL

- 1) A National Inter-Agency Committee to be established to oversee the development and provision of Rehabilitative And Labour Market Services for drug users.
- 2) This Committee shall consist of representatives from the Departments Of Health, Justice, Education and Community, Rural And Gaeltacht Affairs, FÁS and from the Community And Voluntary Sectors.
- 3) Committee representatives shall be of sufficient seniority to ensure policy direction and operational effectiveness.
- 4) Departments, agencies and sectors participating on the Committee shall commit themselves formally in writing to the process.

- 5) It shall have the following Terms Of Reference
 - a. To ensure the development of a coordinated and integrated response to the Rehabilitative And Labour Market needs of drug users, prioritising those in LDTF areas.
 - b. To create and maintain a database on Rehabilitative And Labour Market Services.
 - c. To identify and address gaps in service provision.
 - d. To prepare a development plan re Rehabilitative And Labour Market Services.
 - e. To develop relevant policy proposals.
 - f. To identify Best Practice models arising from the work of the FÁS Special C.E. Projects and disseminate them locally and regionally.
 - g. To facilitate the establishment of local and regional Rehabilitative And Labour Market Services Committees under the aegis of LDTF-RDTFs.
 - h. To monitor and support these committees.
 - i. To review and evaluate the overall effectiveness of this initiative.
 - j. To report to the IDG-NDST at least bi-annually.
- 6) The first meeting of the committee should be convened by the Dept. Of Community Rural And Gaelteacht Affairs before the end of 2004.
- 7) The committee shall appoint an independent chair.

9. Bibliography

- 1) Drugs Misuse Research Unit (1999), National Report on Drugs Issues: Ireland 1999, (Dublin: HRB).
- 2) International Labour Organization (2000), Report V, *Training for Employment: social inclusion, productivity and youth employment*, (Geneva: ILO).
- 3) Organization for Economic Cooperation and Development (1994), *The OECD Jobs Study: Facts, analyses, strategies* (Paris: OECD)
- 4) Wright, G.N. (1980), *Total Rehabilitation*, (Boston: Little, Brown).
- 5) National Institute on Drug Abuse (2003),
<http://www.nida.nih.gov/TXManuals/CRA/CRA1.html>
- 6) Budney, A. and Higgins, S. (2003), *A Community Reinforcement Approach*, (Washington: NIDA).
- 7) Substance Abuse and Mental Health Services Administration (SAMHSA), *Integrating Substance Abuse Treatment and Vocational Services* (2003),
<http://www.ncadi.samhsa.gov/govpubs/bkd381/38h.aspx>
- 8) Menz, F. (1997), "Being in Context with People and Strategies", in *Lessons for Improving Employment for People with Disabilities from Vocational Rehabilitation Research*, (Wisconsin: Stout Vocational Rehabilitation Institute), pp. 49-86.
- 9) Cook, J. and Bond, G. (et al) (1994), *Assessing Vocational Performance Among Persons with Severe Mental Illness* (Chicago: Thresholds).
- 10) Cook, J. (1997), "Community Integration through Vocational Rehabilitation for Persons with Psychiatric Disabilities", in Menz, F. (op. cit.)
- 11) Moyes, H. and Hildebrant, K. , "Washington State's VOTE Program", *State Innovations Briefs*, June 1996.
- 12) Lamb, H. R. (1982), *Beyond Deinstitutionalization*, (San Francisco: Josey-Bass).
- 13) EMCDDA, Final Report (2002).

- 14) Ruddle, H. (et al.), (2001), *Evaluation of Local Drugs Task Force Projects*, (Dublin: Government of Ireland/National College of Ireland/PRC).
- 15) NDST (2004), *Submission to FAS Review*.
- 16) Byrne, D. (2004), *Submission to FAS Review*.
- 17) Wilson, J. (2000), "Substance Abuse in the New Millennium", in *Beyond Maintenance* (Dublin: Veritas).
- 18) Blanchflower, D. and Freeman, R (eds.) (1999), *Youth Employment and Joblessness in Advanced Countries*, (Chicago: University of Chicago Press).
- 19) Drug Misuse Research Division (2000), *Annotated Bibliography of Drug Misuse in Ireland*, (Dublin: HRB).
- 20) Drugs Misuse Research Division (2001), *Overview of Drug Issues in Ireland*, (Dublin: HRB).
- 21) Moran, R. and Pyke, B. (2001), *National Drugs Strategy and Structural Mechanisms*, in "Drugs Issues in Ireland", (Dublin: HRB).
- 22) Indecon International Economic Consultants (2002), *Review of Active Labour Market Programmes*, (Dublin: DETE).

