Evaluation of Phase Two of Blanchardstown Equal Inter-Agency Initiative

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TABLE OF CONTENTS

GLOSSARY **3**

SECTION ONE
INTRODUCTION **5**
1.1 Background 5
1.2 Phase One of the Initiative 5
1.3 Phase Two of the Initiative 6
1.4 Aims of the Evaluation 6
1.5 Format of the Report 7

SECTION TWO
Context and Models of Inter-Agency Work **8**
2.1 Background to Inter-agency Approaches 8
2.2 Blanchardstown's Expertise in Inter-agency working 8
2.3 National Drugs Policy Perspective 9
2.3.1 National Structure 9
2.3.2 Rehabilitation Strategy 9
2.3.3 Continuum Framework 9
2.3.4 National Training Policy 10
2.4 Models of Inter-agency Working 10

SECTION THREE
Evaluation Methodology..... **12**

SECTION FOUR
Outline of the Initiative **13**
4.1 Phase One of the Initiative 13
4.1.1 Agencies involved in the Initiative 13
4.1.2 Systems and Structures 14
4.1.3 Activities and Outcomes 15
4.1.4 Assessment of Phase One 16
4.2 Phase Two of the Initiative 16
4.2.1 Systems, Structures and Finance 16
4.2.2 Activities of Phase Two 17

SECTION FIVE
Evaluation **22**
5.1 Meeting the Objectives in Phase Two 22
5.1.1 Objective One 22
5.1.2 Objective Two 23
5.1.3 Objective Three 23
5.1.4 Objective Four 24
5.1.5 Conclusion 24
5.2 Factors that Contributed to Progress 25
5.2.1 Commitment 25
5.2.2 Protocols 25
5.2.3 Tracking 25
5.2.4 Independent Expertise 25

5.2.5 Funding 25
5.2.6 Independence 25
5.2.7 Agencies and Staff 25
5.3 Factors that Blocked Progression 26
5.3.1 Factors external to the Initiative 26
5.3.2 Factors within the Initiative 26

SECTION SIX
learning for Future Inter-Agency Initiatives 28
6.1 Pilot versus Progression to Mainstream 28
6.2 National Impact 28
6.3 Levels of Service 28
6.4 Leadership 28
6.5 Systems and Structures 28
6.6 Protocols 28
6.7 Data 28
6.8 Commitment and Trust 28
6.9 Group Development 29
6.10 Client Input 29
6.11 Resources 29
6.12 Overall 29

SECTION SEVEN
Recommendations 30
7.1 Blanchardstown Inter-agency Initiative 30
7.1.1 Challenge of Continuation 30
7.1.2 Services 30
7.1.3 Inter-agency Working 30
7.1.4 Monitoring and Tracking 31
7.1.5 Agencies and Projects outside of the Initiative 31
7.1.6 Evaluation and Review 31
7.2 Funders and Policy Makers 31
7.2.1 Support and resource the Initiative 31
7.2.2 Rehabilitation strategy 31
7.2.3 Status of the Initiative 31
7.2.4 Mainstreaming 32
7.2.5 Lead agency 32
7.2.6 Administrative inconsistencies 32
7.2.7 Tracking and monitoring 32
7.2.8 Review and development 32

SECTION EIGHT
Acknowledgements 33

Appendices 35
Appendix One References 35
Appendix Two Four Tiers Model of Treatment 36
Appendix Three Sample Continuum 38
Appendix Four Equal Expenditure Phase Two 39
Appendix Five Steering group Members Phase Two 40
Appendix Six DP Members Phase Two 41

GLOSSARY OF TERMS

The following terms are used frequently in abbreviated form throughout this report.

Blanchardstown Area Partnership	**(BAP)**
Blanchardstown Local Drugs Task Force	**(BLDTF)**
Blanchardstown Offenders for New Directions	**(BOND)**
Community Employment	**(CE)**
Community Drugs Teams	**(CDTs)**
Coolmine Therapeutic Community	**(Coolmine TC)**
Department of Education and Science	**(DES)**
Development Partnership	**(DP)**
Health Service Executive	**(HSE)**
Local Employment Service	**(LES)**
National Drugs Strategy Team	**(NDST)**
Northern Area Health Board	**(NAHB)**
Rehabilitation Integration Service (of the HSE)	**(RIS)**

1. INTRODUCTION AND BACKGROUND

1.1 Background

In 2001, community & voluntary organisations, local development agencies and statutory bodies in Blanchardstown, led by Blanchardstown Area Partnership (BAP), were successful in their application to the Department of Enterprise, Trade and Employment for Equal funding under the Employability pillar.[1] This funding was allocated for the period May 2002- May 2005. It had three elements; one of which was the Blanchardstown Equal Inter-agency Initiative (the Initiative) to develop common protocols for agencies working with current and former drug users.

BAP applied to extend the Initiative.[2] Further funding was allocated until August, 2006. This extension period of the Initiative is referred to as Phase Two in this report.

1.2 Phase One of the Initiative

In 2002, groups and organisations working with current and former drug users (primarily heroin users) became involved in developing an Initiative to respond to three agreed blocks to their progression:

- Services to clients were not being smoothly delivered between agencies,
- There was a lack of co-operation and duplication and overlapping of services, which blocked client progression,
- There were gaps in provision that resulted in clients not accessing appropriate services.

The Initiative proposed to respond to these issues by bringing together all sectors working with current and former drug users. The Initiative proposed to establish inter-agency protocols and create smoother working relationships to enhance the opportunities for drug users to progress towards employment. It proposed inter-agency working at a service level, i.e. collaboration at practical service provision levels for those directly working with drug users.

Eight agencies working with drug users in Blanchardstown and the Blanchardstown Local Drugs Task Force (BLDTF) committed to working together under Equal structures, using Equal funding, to resolve these issues.[3] This work commenced in early 2003.

Phase One had three objectives:

1. To improve the quality of working relationships between all of the agencies involved,
2. To develop a 'lead agency' approach to case management. This agency would assume the lead role in assisting service users and would also co-ordinate the contributions of other participating organisations,
3. To develop clear and workable protocols, especially on service/client confidentiality.

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[1] The Equal Initiative is a laboratory for new ideas to influence the European employment strategy and social inclusion process. Its mission is to promote a more inclusive work life through fighting discrimination and exclusion. Equal is implemented in and between EU member states and is co-funded through the European Social Fund (ESF). It will operate between 2001 and 2008 with a total ESF budget for Ireland of 34 million. There are two funding periods: the first funding round, from 2001 to mid-2005, supported 21 Initiatives in Ireland; a further 22 Initiatives are currently being funded under the second round from 2005 to 2008. The Department of Enterprise, Trade and Employment oversee Equal in Ireland. WRC Social and Economic Consultants are the technical support structure for projects receiving Equal funding. Source: www.equal-ci.ie. Funding is allocated to projects based on approximately 75% ESF funding and 25% from match funding. Match funding is either from a) cash given to the project from another source e.g. HSE b) calculated for the cost of participant agency time participating in the Initiative or c) a combination of both.

[2] See Evaluation of the Work of the Blanchardstown Initiative pages 42-48

[3] See Section 4 for the list of agencies involved in the Initiative.

The former Northern Area Health Board (NAHB), now Health Service Executive, Dublin North Central, through its Rehabilitation Integration Service (RIS), led this Initiative. It worked with the other seven agencies and the BLDTF to implement agreed actions. The group met regularly and engaged an external consultant to work with the group at an early stage to help develop their work.

A Development Partnership (DP), a representative group of the agencies in Blanchardstown Equal, oversaw the Initiative. BAP were responsible for overseeing the Equal budget and liasing with funders.

1.3 Phase Two of the Initiative

Phase One of the Initiative was viewed very positively by the agencies involved, their clients and funders. The Equal evaluation stated that the Initiative "had considerable success in generating increased co-operation between the eight service delivery organisations in Blanchardstown in its work with drug users."[4]

It was also recognised, however, that further action was needed to embed the work in the agencies, prior to promoting the mainstreaming of the Initiative nationally. "Further embedding of the protocols over time has the potential to generate further context innovation and to change these organisations' 'existing settings' (or views of the world)."[5] The agencies involved support this. They recognised the potential benefits of embedding the protocols and associated work practices more deeply into their structures and cultures.[6]

They made a successful application to extend the Initiative from June 2005 to August 2006. The four stated objectives for Phase Two are:

1. To significantly enhance greater inter-agency co-operation among the eight agencies, in order to establish and develop progression pathways in respect of drug rehabilitation needs: to include training, education and employment for current or former drug users,
2. To further research, evaluate and map best practice in respect of inter-agency co-operation,
3. To establish inter-agency tracking systems, in order to ascertain/validate outcomes for end users (i.e. what quantifiable difference will be produced for the service user as a result of greater inter-agency co-operation),
4. To develop and grow the inter-agency protocol model, in order to secure transferability across other sectors as a mainstreaming proposal.[7]

An objective to build on relationships developed in Portugal and the UK in the trans-national work of Phase One was not agreed. All eight agencies and LDTF remained involved with Phase Two and management structures through the DP and BAP remained in place.

1.4 Aims of the Evaluation

In June 2006, the DP commissioned an external evaluation of Phase Two of the Initiative. This phase of the Initiative covers the period June 2005 to August 2006. The five aims of the evaluation are:

1. To critically assess if the agreed objectives for the project extension were met,
2. To assess if the activities that took place were in line with the agreed project proposal and/or if they added value to the Initiative,
3. To outline the key factors that contributed to or blocked progress,

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4 Blanchardstown Equal Initiative, *Evaluation of the work of the Blanchardstown Equal Initiative 2002-2005,* May 2005.
5 ibid
6 Blanchardstown Equal Initiative, *Making Inter-agency protocols work,* October 2004.
7 From the application for extension of the Initiative.

4. To document the learning to inform future inter-agency initiatives and policy development,
5. To make recommendations for the consolidation and development of the Initiative and for other regional and national inter-agency initiatives.

Including making recommendations regarding the following:

a) Agency level regarding commitment to, participation in and implementation of the protocols of this inter-agency initiative,
b) The Steering group of the Initiative with focus on post-extension phase,
c) The consolidation and development of the Initiative in terms of future direction of this group and the possible expansion of its membership to include other relevant agencies,
d) Relevant local and national funders to consider.

1.5 Format of the Report

This evaluation report is presented under seven sections.
Section Two outlines the current context and models of Inter-agency working.
Section Three outlines the methodology used to carry out the evaluation.
Section Four outlines a description of activities that took place in Phase One and Phase Two of the Initiative.
Section Five outlines the evaluation analysis.
Section Six outlines the key learning from Phase Two of the Initiative.
Section Seven outlines the recommendations.
The Appendices provide supporting information.

2. CONTEXT AND MODELS OF INTER-AGENCY WORK

2.1 Background to Inter-agency Approaches

For over a decade, national policy makers have pursued a collaborative approach to decision-making. Clear examples of this are found in national social partnership agreements that continue to lead and frame economic reform. Area Based Partnerships, Blanchardstown Local Drugs Task Forces, City and County Development Boards and Childcare Committees are other examples of collaboration used to plan, respond to development and to specific social and economic issues. This approach to decision making seems set to continue. In fact, the recently agreed social partnership arrangement suggests that collaboration will remain as a central component for policy development into the future.

Although this collaborative approach may be one of the parts of the current sustained economic position, its successes in social policy reform are less obvious. This view is the central premise of the NESC Report 113 "The Developmental Welfare State".[8] This report concludes that there is a need to completely reform our social policy and welfare system to address deeply rooted social problems. It highlights that resources alone will not address these issues: we need new ways of working, new policy instruments and institutional innovations. This report compares the innovation and experimentation required to change current social policies to the research and development that drives private sector change. It outlines that the community & voluntary sector are, historically, more successful in creating innovative solutions to complex issues. That thinking is important for this Initiative, as it brings the community & voluntary, local development and statutory agencies working on drug issues in Blanchardstown together. From here, they can innovate to deal with complex drug progression problems using a collaborative approach.

This report promotes a collaborative approach that focuses on outcomes and accountability. It advocates flexibility in using resources. The report outlines five key strategic and operational requirements in order for progress to occur. They are a) governance and leadership, b) rights and standards, c) integration at the local level, d) operational requirements and e) supporting people across the life cycle.

2.2 Blanchardstown's Expertise in Inter-agency Working

The community, voluntary and statutory organisations in Blanchardstown are experienced and are successful in working together within and between their sectors. Structures like the Blanchardstown Area Partnership and the Blanchardstown Local Drugs Task Force have effectively brought local groups, organisations and agencies together to develop shared visions and to agree strategies to tackle complex social and economic issues. A 2003 report highlighted that commitment to inter-agency work in Blanchardstown was very high.[9] This was clear from the shared analysis of community needs and the ethos of mutual support and co-operation in the area.

The application for Equal funding in 2001, by a consortium of organisations in Blanchardstown, was the only successful area-based application for the first round of Equal funding. This reflected the experience and commitment of the agencies in Blanchardstown to inter-agency processes as a mechanism to tackle complex issues.

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8 NESC Report 113, *The Developmental Welfare State*, May 2005

9 Rourke, S *"Local development and community development structures in the Blanchardstown area"*, June 2003. This report focussed on BAP, BLDTF, RAPID and four community development projects in Blanchardstown.

2.3 National Drugs Policy Perspective

2.3.1 National Structure

The Department of Community, Rural and Gaeltacht Affairs has responsibility for co-ordinating the implementation of the National Drugs Strategy. A number of departments and agencies implement the strategy. Central to this are the Local and, more recently, the Regional Drugs Task Forces. Drugs Task Forces identify and plan local responses to drugs issues using inter-agency approaches.[10] The plans developed by each Drug Task Force are based on the four pillars of the National Drugs Strategy: a) Supply Reduction, b) Prevention, c) Treatment and d) Research. However, many Task Forces have extended their work to include rehabilitation.

2.3.2 Rehabilitation Strategy

There is no agreed national rehabilitation strategy, definition of rehabilitation or agreed model of a continuum of care. A recent policy report on the treatment of under-18-year-olds outlines a four-tier model, adapted from the UK, as a framework for a multidisciplinary approach to service delivery for their treatment needs.[11] The mid-term review of the National Drugs Strategy highlights the need for a fifth pillar to strengthen and expand rehabilitation provision.[12] It outlines that differing views of rehabilitation exist, based on a) therapeutic and b) social re-integration models, and that a national strategy had to be in place before a "comprehensive policy and individual actions on rehabilitation can be developed."[13] This is central to the development of a continuum of care for drug users that offers "seamless client-centred service" and "planned programmes of progression".[14]

Developing an agreed rehabilitation strategy is a complex task, particularly because of the differing views of rehabilitation. The rehabilitation strategy, currently being written by the National Rehabilitation Working Group is at draft consultation phase and is due to be in place before the end of the year. It outlines a number of recommendations: one is to promote an inter-agency approach, based on an agreed continuum of care. It also recommends the development of agreed protocols between agencies. This fits with the focus of this Initiative. It acknowledges that treatment needs an adequate level of provision. Also, agencies such as the HSE and Department of Education and Science (DES) should complement Community Employment (CE) schemes. It recommends employing rehabilitation co-ordinators to further the work outlined above. The draft strategy also highlights the need for effective systems for case management and monitoring/tracking. It draws attention to the current gaps in agreed standards of service and in associated staff development. This strategy will shape the policy framework on the development of rehabilitation services for drug users in the future.

2.3.3 Continuum Framework

In the absence of an agreed national continuum that maps the stages of client progression, we use the following framework throughout this report. It aids the description and analysis of this Initiative's work. The continuum framework is as follows:

a) *Chaotic* **drug use** - shown through frequent drug use that seriously impacts on all aspects of the user's life. Initial responses include assessment, drop in, crisis intervention and harm reduction programmes such as needle exchange,

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10 www.pobail.ie
11 See Appendix Two for an outline of the four-tier treatment model.
12 Department of Community, Rural and Gaeltacht Affairs, "Mid-Term Review of the National Drugs Strategy 2001-2008", 2005.
13 ibid.
14 ibid.

b) *Stabilisation* **of drug use** - this is a possible next stage in harm reduction. Responses include methadone maintenance programmes, and work on ancillary issues such as self esteem and housing issues,
c) *Detoxification* **of drug use** - following stabilisation to an agreed level, drug users may detoxify. This can occur in the community through GP support or through residential detoxification,
d) *Drug free* - clients at this stage may opt to participate in a drug free residential programme or continue to live in the community. Training, education and addressing ancillary issues such as housing are focussed on at this stage. These issues, however, are often also worked on when clients have stabilised or are detoxifying.

The focus of this Initiative was on inter-agency working to progress clients towards the workplace, thus focussing on rehabilitation. These clients were either stabilised, detoxifying or drug free.

2.3.4 National Training Policy

FAS commissioned a national review of CE Drugs Task Force places in 2004, this is widely known as The Bruce Report.[15] This review examined the impact of 1,000 CE places that are ring-fenced by FAS since 1997 for Local Drugs Task Force areas. It outlines "International evidence shows that 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".[16] It outlines a number of problems that these CE schemes have encountered, mainly as a result of CE often being the only training option for drug users. Many clients, therefore, are accessing CE in the absence of other rehabilitative options. Inter-agency working with the HSE and other relevant community and voluntary sector bodies is not working with FAS to use these schemes in the manner that they were intended. The Bruce Report outlines a number of recommendations for the future development of training options for drug users: one of these is to establish a National Inter-agency Committee to oversee the development and provision of rehabilitative and labour market services for drug users.

2.4 Models of Inter-agency Working

There have been a number of academic studies on inter-agency working. Three particularly relevant studies are: Atkinson et al, Kickert et al and Roberts.[17] These studies use different terminology to describe inter-agency working: trans-organisational systems (Roberts), multi-agency working (Atkinson) and policy networks (Kickert). Each have the same premise, however, and agree that inter-agency working exists when a group of people come together from different agencies to use their skills and knowledge to solve a common problem. "They are able to make decisions and perform tasks on behalf of their member organisations, although members maintain their separate organisational identities and goals. Trans-organisational members remain accountable to their organisations of origin."[18] This Initiative echoes this thinking, as its Steering group is made up of senior staff representatives that have the authority to make decisions on behalf of the agency that they represent.

Roberts outlines that all problems have solutions but that meta-problems (e.g. drugs, gangs, poverty) do not have straightforward solutions. In these instances, trans-organisational approaches may be required.[19] This was the key reason that the agencies in Blanchardstown decided to apply for funding that led to Phase One, and subsequently Phase Two, of the Initiative. Roberts outlines six steps for successful trans-organisational

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15 Bruce, A *"Drugs Task Force Project Activity for FAS Community Employment Participants, A Review"*, July 2004.
16 Bruce, A *"Drugs Task Force Project Activity for FAS Community Employment Participants, A Review"*, July 2004.
17 Atkinson, M et al *"Multi-agency working models, challenges and key factors for success"*, 2005; Roberts, J *"A Six-Step Development Framework to Build Successful Alliances, Coalitions and Partnerships", 2005;* Kickert, W et al *"Managing Complex Networks"*, 1997.
18 Roberts, J *"A Six- Step Development Framework to Build Successful Alliances, Coalitions and Partnerships"*, 2005.
19 Ibid.

approaches. Through these steps, he emphasises the need for the members of the trans-organisational system to agree to a common vision and to support and build the group's architecture. It is important, therefore, to ensure that leadership, governance, trust and management exist in order for the trans-organisational system to work effectively. The Initiative made a decision early in Phase One to contract an external consultant to work with them. It helped them to develop their vision and to ensure that the group's processes developed throughout the Initiative. The evaluation of Equal 2002-2005 highlights this as a key factor in the success of the Initiative during this phase.[20]

Atkinson et al outline a number of key factors that enable or prevent the success of multi-agency initiatives.[21] A number of these fit with Roberts thinking and include the need for: clear roles and responsibilities, management at strategic levels, communication and sharing information and resources. The evaluation of Phase One of the Initiative outlines the impact that these factors had in this initial stage of the Initiative. Kickert concurs with Atkinson's views on policy networks sharing financial resources and information.[22]

[20] Blanchardstown Equal Initiative, *"Evaluation of the work of the Blanchardstown Equal Initiative 2002-2005"*, May 2005.
[21] Atkinson, M et al *"Multi-agency working models, challenges and key factors for success"*, 2005.
[22] Kickert, W et al *"Managing Complex Networks"*, 1997.

3. EVALUATION METHODOLOGY

The evaluation used literature review, telephone interviews, individual interviews and focus groups. All relevant stakeholders had an opportunity to contribute to the evaluation. This included all members of the Inter-agency Steering group, the DP and the National Drugs Strategy Manager with the HSE. Full details of the evaluation research are as follows:

- Review of relevant literature and documents, including: Phase Two Extension Plan, the evaluation report from Phase One, the Tracking Report, protocols produced by the Initiative, national and international policy documents, the Review of the National Drugs Strategy and other relevant documents,

- Two semi-structured focus groups with the Inter-agency Steering group and the DP, lasting between 30 minutes and two hours. Four agencies were represented at the Steering and seven at the DP focus groups. The material gathered was documented during the focus groups,

- Three semi-structured face-to-face interviews with the RIS Acting Co-ordinator, a CDT Co-ordinator and Deputy Manager of BAP lasting between 30 minutes and an hour-and-a-half. The material gathered was documented during the interviews,

- Five telephone interviews with a variety of stakeholders, each lasting between 30 minutes and an hour. These were held with the HSE National Drugs Strategy Manager, the BLDTF Co-ordinator, a CDT Co-ordinator and two agency staff that are implementing the protocols. The material gathered was documented during the interviews,

- Two interviews with clients, lasting between 30 and 45 minutes. Interviews with four other clients took place as part of the Tracking process. This evaluation also takes these outcomes into consideration.

4. OUTLINE OF THE INITIATIVE

The evaluation used literature review, telephone interviews, individual interviews and focus groups. All relevant stakeholders had an opportunity to contribute to the evaluation. This included all members of the Inter-agency Steering group, the DP and the National Drugs Strategy Manager with the HSE. Full details of the evaluation research are as follows:

This section outlines the activities and key outcomes of Phase One. It also describes the activities of Phase Two and how they were implemented.

4.1 Phase One of the Initiative

Phase One of the Initiative identified that personal working relationships played a fundamental role in determining inter-agency contact and referrals.[23] There were different formal and informal relationships / understandings between agencies. There were substantial information gaps about the services provided by other relevant agencies. These factors resulted in an inconsistent approach to inter-agency working.

The Initiative was designed to achieve substantial positive change in the way that the agencies involved work with drug users and interact with each other.[24] The objectives of Phase One are outlined in section 1.2.

4.1.1 Agencies involved in the Initiative

Eight independent agencies and the Blanchardstown Local Drugs Task Force (BLDTF) participated in the Initiative. These agencies vary in size and focus: some agencies respond solely to drug issues and others respond to a range of issues stemming from social exclusion, which include drug use. The following table outlines the names of the agencies involved, the sector they are from, whether they respond specifically to drug issues and an approximate number of staff employed by each agency:

Name of Agency	Sector	Focus of Agency	No. of staff
Mulhuddart/Corduff Community Drugs Team (MCCDT)	Voluntary, community-based	Drugs specific. Works on a number of levels with clients from harm reduction to rehabilitation.	Co-ordinator=1 Project Workers=3 Outreach Worker=1 Administrator=1
Mountview/Blakestown Community Drugs Team (MBCDT)	Voluntary, community-based	Drugs specific. Works on a number of levels with clients from harm reduction to rehabilitation.	Co-ordinator=1 Team Leader=1 Project Workers=3 Administrator=1 Receptionist=1 (Jobs Initiative) Childcare Workers=2 (one part-time) Cleaner=1
Hartstown/Huntstown Community Drugs Team (HHCDT)	Voluntary, community-based	Drugs specific. Works on a number of levels with clients from harm reduction to rehabilitation.	Co-ordinator=1 Project Workers=4 (one part-time) Outreach Worker=1

[23] Sheehan, Cormac
[24] Blanchardstown Equal Initiative, *"Making Inter-agency protocols work"*, October 2004.

Name of Agency	Sector	Focus of Agency	No. of staff
Local Employment Service (LES)	Managed by local development structure (BAP)	Works with a broad base of clients experiencing social exclusion, including drug users, to enter employment.	Manager=1 Mediators=6 Contact Support=5 Employer Liaison=1 Administrator=1
Coolmine Therapeutic Community (Coolmine TC)[25]	Voluntary, national organisation	Drugs specific. Runs two residential units in Blanchardstown. These were part of the Initiative.	Coolmine Lodge Manager=1 Project Workers=5 complemented by a relief panel Ashleigh House Manager=1 Project Workers=3 complemented by a relief panel
Blanchardstown Offenders for New Directions (BOND)	Voluntary, community-based	Works with young ex-offenders. Many of BOND's clients experience drug issues.	Director=1 Day service Manager = 1 Project Workers=3 Sessional Workers=4 Administrator (Jobs Initiative)=1 Residential Team Leader =1 Project Workers=3
Tolka River Rehabilitation Project (Tolka River)	Voluntary, special CE drugs project, community-based	Drugs specific. CE training scheme.	CE scheme, currently closed for review.
Rehabilitation Integration Service (RIS)	Statutory	Drugs specific. Rehabilitation focus.	Co-ordinator=1 (part-time) Project Worker=1 A second project worker is due to start in the autumn.

This Initiative was supported by the Blanchardstown Local Drugs Task Force, through its' Co-ordinator.[26]

4.1.2 Systems and Structures

The Initiative was developed by a Steering group, composed of representatives with senior positions from all of the agencies involved. The composition of the group was agreed to enable speedy decision-making. The RIS Co-ordinator chaired and led Phase One of the Initiative. The quality and background of the members was of vital importance. They were highly committed to the process because the outcomes were directly relevant to their work. The emphasis on participation and feedback ensured that the Steering group consulted and took into account the views of their staff.[27] The Steering group met regularly throughout Phase One.

[25] Coolmine Therapeutic Centre operates other services outside of Blanchardstown that are not part of this Initiative.
[26] The roles of the LDTFs are outlined in Section 2.3.1. The BLDTF in Blanchardstown currently employs a co-ordinator, one support and development worker and one administrator.
[27] Blanchardstown Equal Initiative, *"Making Inter-agency protocols work"*, October 2004.

The Steering group quickly realised that it needed a dynamic, highly-participative process if it was to succeed. They appointed a neutral external consultant to work with the group. This independent brokerage, along with the ownership created by participative working methods, set the tone for honest and open debate and decision-making.[28]

The Blanchardstown Equal Co-ordinator also worked with the inter-agency group by: supporting the chairperson to circulate reports and minutes, linking the group to Blanchardstown Equal events and linking the group to other national and trans-national Equal events.

The group reported on its progress and communicated with Blanchardstown Equal, through the Steering group chairperson, at monthly DP meetings. The DP's role was to oversee the implementation of the Equal plan across all three elements, of which this Initiative was one.

4.1.3 Activities and Outcomes of Phase One

Three main aspects to the Initiative were worked on in Phase One:

a) Improving the quality of working relationships between all of the agencies,
b) Developing a 'lead agency' approach to case management,[29]
c) Developing clear and workable protocols, especially on service/client confidentiality.

The eight agencies involved in the Initiative took a number of steps to build trust, to understand the work of each agency and to share relevant information. While the Steering group led the Initiative, frontline staff were involved through 'information sharing' days, through combined staff training and through developing the protocols. High levels of consultation took place: issues were taken on board and responded to, e.g. through staff training and amending written materials.

The eight agencies developed protocols on lead agency working and confidentiality. They piloted these protocols for three months and all of the agencies involved were happy to progress with the Initiative. This testing and development period ran in tandem with other participative activities that increased ownership and communication.[30] All of the agencies' management committees agreed and signed up to the final protocols. The Initiative also developed guidelines on how to use the protocols. These protocols were launched at a major seminar, which was attended by key policy makers and European interests who had met through the trans-national element of Equal.

The Initiative put a tracking system in place for the months February, March and April 2004. All of the agencies involved in the Initiative used this system. During the three months, the tracking process indicated an increase of activity between the agencies, including:

- The number of inter-agency referrals was 73,
- The number of three-way meetings increased from 0 to 17,
- The number of lead agency referrals increased from 0 to 6,
- The number of inter-agency activities was 96.[31]

[28] Ibid.
[29] Lead agency = One agency that assumes the lead role in assisting clients and co-ordinates the contributions of other participating agencies.
[30] Blanchardstown Equal Initiative, "Making Inter-agency protocols work", October 2004.
[31] Blanchardstown Equal Initiative, *"Evaluation of the Work of the Blanchardstown Equal Initiative 2002-2005"*, May 2005

4.1.4 Assessment of Phase One

Phase One of the Initiative was evaluated as part of the Blanchardstown Equal evaluation. The Initiative received a very positive evaluation: it noted that the Initiative had considerable success in increasing co-operation between the agencies. This occurred between agencies of different sizes, coming from differing backgrounds within the community and voluntary, local development and statutory fields. The Initiative was seen to be innovative: "It was innovative as regards context in that the new processes both stemmed from, and drove, changes in the ways the organisations saw themselves and their work".[32]

It also highlighted a number of factors that were important in the success of the Initiative, which include the:

a) Importance of the lead driver, the RIS,
b) Centrality of trust among the agencies,
c) High level of communication and consultation,
d) Appointment of an external consultant,
e) Commitment of the agencies involved,
f) Commitment of the Steering group,
g) Importance of the action plan.

The evaluation highlighted the need for the agencies involved to embed the protocols and the associated work practices more deeply into their structures and cultures. It also stressed that the Initiative had potential for mainstreaming, to expand the Initiative "There is every reason to believe that similar improvements in inter-agency co-operation could be obtained in other parts of Ireland for drug users" and to replicate it across other target groups locally and nationally "While this action focussed on drug users, there is no reason to believe that similar work could not occur (and services be improved) in relation to other target groups."[33]

4.2 Phase Two of the Initiative

At the end of Phase One, the agencies agreed that the Initiative had been successful. They felt, however, that the timeframe to embed the work in their organisations was limited. On this basis, an application was made to the Department of Enterprise, Trade and Employment to extend the Initiative for a year. This application was successful and the Initiative was extended from June 2005 to August 2006.

4.2.1 Systems, Structures and Finance

All of the agencies involved in Phase One continued their involvement in the Initiative in Phase Two.

The Steering group carried on into Phase Two, and continued to meet regularly. They engaged the same external consultant to work with the group in Phase Two.

There was, however, an unusually high level of change at senior management level in the eight agencies. Of the eight agencies involved in the Initiative, six Co-ordinators changed.[34] The representative of the lead agency (RIS), who provided much of the leadership, was one of those that left the Initiative. In fact, the RIS representative on the Steering group changed twice in Phase Two. These changes meant that, although the same agencies participated in Phase Two, there was a different Steering group. Four of the Steering group representatives were also new to the area.

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32 Ibid.
33 Blanchardstown Equal Initiative, *"Evaluation of the Work of the Blanchardstown Equal Initiative 2002-2005"*, May 2005.
34 One of the agencies, BOND, was represented on the Steering group by their manager. While the director of this agency changed, therefore, it did not affect the Steering group.

The contract of the Equal Co-ordinator and Equal Administrator was extended on a part-time basis. The Administrator left at the end of Phase One and was not replaced. In January 2006, the Co-ordinator resigned. From March until August, an external consultant was contracted to co-ordinate Phase Two.

The consultant, who designed and implemented the initial stages of the tracking process, withdrew from the process in January 2006, as she was not in a position to complete the work. Another consultant replaced her.

Although the two other elements of Blanchardstown Equal were not extended, the funding stipulated that the DP structure remain in place. The numbers on the DP reduced. Organisations with a core drugs remit or inter-agency brief that were most interested in continuing to be involved on the DP for Phase Two remained. BAP retained overall responsibility for the extension period to funders. Personnel change also affected the DP as many of the key leaders and drivers of the Blanchardstown Equal Initiative on the DP also moved out of the area.

The reporting structure to the DP changed as the new chairperson of the Initiative did not have a position on the DP. The BLDTF Co-ordinator, who was nominated from the Steering group onto the DP, filled this role.

Phase Two had a funding allocation of €135,659. €116,755 was ESF funding and €15,000 match funding, in cash, from other agencies. Participant agency funding, allocated as agency time relating to the Initiative was €3,904. Therefore €135,659 was available to the Initiative to spend. Of the total budget, €99,786 was spent. This left €35,873 in actual funding unspent in Phase Two.[35] This was mainly due to not recruiting an Administrator and lower than anticipated costs for Co-ordination as the associated position was contracted from March.

4.2.2 Activities of Phase Two

There were four stated objectives in Phase Two. Each objective was accompanied by an agreed series of actions. The following outlines the stated objectives and actions with the activities that actually occurred in Phase Two:

OBJECTIVE ONE:
To significantly enhance greater inter-agency co-operation amongst the eight agencies in order to establish and develop progression pathways in respect of drug rehabilitation needs; to include training, education and employment for current or former drug users.

Stated Action (1)	Activities carried out
Induction in the protocols for new staff	Induction training across the eight agencies in the Initiative took place. A calendar to repeat this training is in place.

The Equal Co-ordinator and the BOND representative on the Steering group organised the induction training. The purpose of the training was to enable the agencies to be self-sufficient in doing their own induction and to have a standardised induction process for all of the agencies involved. Ten new staff from five agencies attended this training.

[35] See Appendix Four for a breakdown of the budget in Phase Two.

Stated Action (2)	Activities carried out
Induction module development for inclusion in agencies induction and job descriptions	Seven of the agencies and the BLDTF have inserted interagency working into job descriptions. Four agencies specifically mention the protocols; the other three agencies have a more generic statement on inter-agency working. BOND has an induction training programme that includes induction on the protocols. Coolmine TC also has a structured induction/training programme. Induction training in the other agencies is less structured and is organised on a case-by-case basis. Evidence does suggest, however, that in the majority of cases, new staff are briefed on the protocols during their induction period.

The majority of agencies have included inter-agency working in job descriptions. Six of the agencies do not operate a planned programme of induction training. New staff are inducted on a case-by-case basis. Briefing on the protocol materials, however, does appear to be included in all instances.

Stated Action (3)	Activities carried out
Staff Training on: a) Joint development of care-plans b) Move from pilot to best practice Ongoing familiarisation with protocol use, particularly in respect of lead agency working	Interagency staff training took place in February 2006 on three-way meetings. Three information sessions on the services provided by agencies took place. Interaction is occurring between some of the agencies on a more frequent basis, e.g. all relevant staff from the LES and Coolmine TC met to share how they work and are now working more closely together. RIS and Coolmine TC meet fortnightly to discuss client progress.

Staff training took place in February and was facilitated by the external consultant. From six agencies, 18 staff participated in this training. The purpose of the training was to help staff conduct three-way meetings. During the course of the training, however, it emerged that a number of other issues existed, that blocked inter-agency work. These included the lack of assessment of clients and either the lack of or an inconsistent approach to care planning in some of the agencies. Issues that emerged at the training were fed back to the Steering group. A sub-group of the Steering group are developing training for joint care planning.

While the training was aimed at staff, two members of the Steering group also participated. Those two members had not been involved in Phase One. When applying for funding to extend the Initiative it had been anticipated that Steering group members would deliver this type of training in Phase Two.

The Equal Co-ordinator assessed the information requirements of staff from the agencies involved in the Initiative. Staff highlighted the need for more information on BOND, RIS and Coolmine TC. These three organisations organised information sessions in their premises, which lasted approximately an hour-and-a-half. An average of twelve staff attended each information session.

Some agencies, e.g. LES and Coolmine TC, also responded to specific information and communication deficits by organising joint meetings of staff to discuss and address these issues. This resulted in the staff from these agencies working more closely together. Recent changes within Coolmine TC have resulted in one staff

member liasing with the RIS. Both agencies now meet fortnightly to discuss common clients. Coolmine TC has also visited the three CDTs to outline changes in their service and to explore potential joint service development opportunities.

STATED OBJECTIVE TWO

To further research, evaluate and map best practice in respect of inter-agency co-operation

Stated Action (1)	Activities carried out
Simplification of protocols language, more appropriate to clients	The confidentiality form was simplified. The release of information form was proofed by the National Adult Literacy Association (NALA) and amended.
Training for Managers and the Steering group: a) Managing Change, b) Organisation Development, c) Concepts and Models for Multi- Agency working.	There was no formal training set up for Co-ordinators or the Steering group.

The Equal Co-ordinator organised the simplification of forms with support from inter-agency group members. No training for the co-ordinators involved in the Steering group took place.

STATED OBJECTIVE THREE

To establish inter-agency tracking systems in order to ascertain/validate outcomes for end users (i.e. what quantifiable difference will be produced for the service user as a result of greater inter-agency co-operation)

Stated Action	Activities carried out
Agreement in areas of progression Development of a tracking system to: a) Monitor/track clients progression, b) Monitor/track inter-agency actions, c) Evaluate the process.	A tracking system was piloted in November/December 2005 and adjusted and implemented monthly until April 2006.

The Initiative engaged an external consultant to develop and implement the tracking process. She withdrew from the project. In January 2006 a second consultant was contracted to continue the work. The tracking system was in progress at this time. It involved each agency returning a detailed questionnaire, on a monthly basis to the consultant, of their inter-agency activity at an agreed date. The outcomes of November and December were used as a pilot phase of the tracking. The forms were amended following this pilot phase

The tracking system used primarily quantitative data but was supplemented by client interviews to add a qualitative dimension to the work. A report on the outcomes of the tracking was produced.[36] It outlines:

a) The levels of inter-agency co-operation,
b) The extent and level of outcomes for service users as a direct result of inter-agency co-operation.

This report noted that there were some limitations to the system of collating data, which had implications for accuracy. The report, however, outlines some very important findings.

[36] Burtenshaw Kenny, *"Report for the Inter-Agency Tracking System (November 2005-April 2006)"*, 2006.

STATED OBJECTIVE FOUR

To develop and grow the inter-agency protocol model in order to secure transferability across other sectors as a mainstreaming proposal

Stated Activity	Activities carried out
Replication/testing of model in: a) HSE clinical team and the CDTs, b) Other agencies not in the pilot.	Funding was secured through the BLDTF to develop treatment protocols between the HSE clinical team and the CDTs.

An application was made by the CDTs, in consultation with the HSE clinical team, through the BLDTF, to the 'emerging needs' fund: this was to develop protocols for agencies involved in treatment of drug users. This application was successful and is due to start before the end of the year. The main agencies that will be involved in these protocols are the HSE clinical team and the CDTs.

Other activities that took place in Phase Two

A number of activities took place in Phase Two that were not part of the agreed plan.

Training options for clients

Due to a shortage of services in the area, a large number of clients access detoxification, education, training and accommodation supports outside of Blanchardstown. The RIS works with a large number of clients at this rehabilitation stage and links them to services outside of Blanchardstown. They are using the protocols, such as the release of information forms, with these agencies, e.g. the Keltoi Therapeutic and Rehabilitation Unit (Keltoi).[37]

A training programme, "Bridge to the Workplace", was organised by a consortium of interests, including the LES and RIS.[38] The agencies involved from Blanchardstown indicate that this course is very successful for drug users who are progressing into the workplace. A client interview confirmed this. This programme has 14 drug users from Blanchardstown who are successfully engaging in high-quality work placements in sites such as the National Museum.

The RIS, in consultation with the CDTs and Tolka River, developed a training course for clients who are currently not involved in any structured training or education programme. The LES and the CDTs had identified this gap during Phase One of the Initiative in 2004. A Steering group to access/manage funding and to run the course is in place. Funding was recently approved through the BLDTF for an initial pilot course, which will start in October or November. It will be run with two separate groups- former drug users who are drug free and those on methadone maintenance.

Meeting with senior officials

A meeting of senior officials was called by the DP to discuss inter-agency work and the experience of the Initiative. This meeting was well attended by key Department officials. It is agreed that representatives from the DP, who are also Steering group members, will work with the National Drugs Strategy Manager of the HSE and the National Drugs Strategy Team (NDST) Co-ordinator to develop a short position paper to outline the issues and blocks experienced by the agencies in Blanchardstown. The paper will be developed following this evaluation report.

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[37] Keltoi is a therapeutic residential unit, which works with drug free clients to complete an eight-week intensive programme. This programme places a strong emphasis on occupational, work and is run by the HSE.

[38] *"Bridge to the Workplace"* is a collaborative venture involving: HSE /RIS, FAS, Blanchardstown LES, Finglas Cabra Partnership, Northside LESN, Ballymun Job Centre, Dublin Inner City Partnership and Local Drugs Task Forces in Blanchardstown, Finglas/Cabra, North Inner City, Ballymun and Dublin North East.

Internal organisational change

Some organisations, such as the CDTs, are working together to address internal issues that emerged during Phase Two such as staff management systems and client recording systems. Individual CDTs are also reconsidering the roles of their staff and how their services are offered to clients such as operating different service times for different categories of clients and specialising staff roles.

Impact on other organisations

Organisations working with young people in Blanchardstown are meeting to consider adapting the protocols to assist them in delivering more seamless services.

Additional protocols/guidelines developed in Phase Two

The Initiative agreed a "Troubleshooting protocol" to respond to issues that might arise between agencies. It also developed guidelines for new membership to the Inter-agency Steering group.

5. EVALUATION

This section of the report:

- Assesses if the objectives set in the agreed project extension proposal were met,
- Outlines key factors that contributed to and blocked achievement of the objectives

5.1 Meeting the Objectives in Phase Two

5.1.1 Objective One

"To significantly enhance greater inter-agency co-operation amongst the eight agencies in order to establish and develop progression pathways in respect of drug rehabilitation needs; to include training, education and employment for current or former drug users"

In Phase Two, there is evidence, through the tracking and from the interviews that inter-agency activity and co-operation has definitely increased. 146 referrals were made within the Initiative during the six-month tracking process and 60% of these referrals were to agencies that work on the later stages of progression i.e. RIS and LES.

The agencies are very familiar with each other's work. The tracking report highlights that staff awareness of referral and comfort levels in referring to the other agencies are high. The inclusion of briefings on the protocols in induction processes and information sessions has contributed to this.

Although it was not possible to establish the exact number of meetings, there is evidence of a high level of inter-agency meetings with clients (approximately 93 over the tracking period). Again patterns did emerge.[39] Coolmine TC works closely with LES and RIS. As Coolmine TC clients are drug free, the LES and RIS are well placed to work with them in their next stage of progression. Tolka River and the CDTs work closely together. The majority of inter-agency meetings were with agencies focussing exclusively on progression.

All clients interviewed could identify positive outcomes from the inter-agency process. Outcomes included, mapping their potential progression, planning for residential rehabilitation, CE schemes and training. They had all engaged with a number of agencies involved in the Initiative using the protocols and, in the vast majority of instances, were aware of their lead agency. Clients did not have concerns about sharing information or signing the confidentiality forms as they recognised that they needed different inputs at different times during their progression.

Progress on developing pathways for clients, however, has proved to be more difficult to achieve. Basic systems and structures to enable embedding of the Protocols do not yet exist in some organisations, e.g. clear assessment procedures, care-plans, client recording systems or induction training. This is perhaps not surprising as the majority of agencies involved in the protocols are small, community-based agencies. These agencies are focussed on practically trying to meet the needs of the most chaotic, vulnerable members of society who are often in crisis. The skills and expertise of these agencies lies in responding to these needs.

There is agreement at national level that projects that are mainstreamed by the HSE have responsibility to monitor and support their development. However, in practice this role is not clear.

[39] This is due to a lack of records to verify that meetings took place and a lack of clarity regarding who initiated the meetings.

There are major obstacles to developing progression pathways for clients. For example, a) paths to detoxify are limited, b) methadone users who want to reduce their levels of usage are often unaware of why they are not supported to do so by their prescribing doctor, c) specialist training and education opportunities, which are often necessary to aid progression of clients and move them closer to the mainstream workplace, are extremely limited. The "Bridge to the Workplace" training course, which has been running during Phase Two of the Initiative, is a pilot programme whose future is not clear. The "Right Steps" programme, which aims to fill a constantly-highlighted gap in first step training, is due to start in the autumn on a pilot basis. The absence of a national rehabilitation strategy, of an agreed continuum of progression or of the appropriate local services, therefore, has an impact on the development of local progression pathways.[40]

Existing training does not always meet the needs of the client. It is acknowledged that FAS-funded special CE drugs projects play an extremely important role in rehabilitation. The challenge, however, of using a labour market mechanism as a rehabilitative tool has been raised: "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."[41] The Bruce Report also states that a comprehensive rehabilitation service is essential to ensure that drug users on CE schemes do not go back to where they started. Clients involved in Tolka River raised a number of issues about this training course. This agency is currently closed for review. Clients want structured training courses that allow them to develop their skills and address their drug usage. All clients interviewed noted the importance of services not mixing clients who are at different progression points, e.g. clients who are drug free or stable attending the same service at the same time as active drug users.

5.1.2 Objective Two

"To further research, evaluate and map best practice in respect of inter-agency co-operation"

A problem with evaluating this objective is that there is limited correspondence between the objective and the actions outlined in the proposal to meet this objective.

However, actions undertaken under other objectives have contributed to research, evaluation and mapping of best practice. For example the tracking process outlined under objective three below, provides very useful information on the process of inter-agency co-operation in this area.

Two reports a) on the tracking and b) this evaluation report took place during Phase Two. Both reports highlight the achievements and key learning from this Initiative on inter-agency collaboration at local practical level. A client perspective was included in both reports. The lessons learnt can be used to inform the future inter-agency work of this and other similar Initiatives.

The stated action relating to the simplification of protocol texts was achieved and partly validated by NALA.

The stated action in relation to training managers and the steering group was not carried out. Funding was not made available for this action.

5.1.3 Objective Three

"To establish inter-agency tracking systems in order to ascertain/validate outcomes for end users (i.e. what quantifiable difference will be produced for the service user as a result of greater inter-agency co-operation)"

[40] In the UK, a continuum for treatment exists, which clearly outlines the types of treatment services each area should have, that is an agreed national policy.
[41] Bruce, A *"Drugs Task Force Project Activity for FAS Community Employment Participants, A Review"*, July 2004.

Tracking in Phase Two built on the limited tracking that took place in Phase One. The outcome is a more structured assessment of the inter-agency activity that occurred. The tracking process concentrated on tracking activities between the agencies. Non-systematic client interviews were also used to assess the impact of the Initiative on service users.

It became clear during Phase Two that many of the agencies could only offer limited client measurement systems and that the establishment of an extensive system of tracking all relevant clients was beyond the scope of this Initiative: such a system would require dedicated planning and funding. Even though difficulties existed, however, all agencies submitted information on their clients for the period November to April 2006. This is a reflection of the commitment of the agencies to the Initiative despite the difficulties that the task posed.

5.1.4 Objective Four

"To develop and grow the inter-agency protocol model in order to secure transferability across other sectors as a mainstreaming proposal"

Phase Two did develop the protocol model, particularly at implementation level. It moved from being a pilot template of best practice into a central part of how agencies aspire to work with each other. The protocols have become the benchmark for best practice inter-agency working. The model extended to include a protocol on responding to issues that may emerge between agencies. There were considerable challenges, however, in embedding the change of practice in organisations for the longer term. This was due to the considerable change needed by many of the agencies to their existing systems, structures and cultures in order for the model to be completely engrained as a way of working. These difficulties became more apparent in Phase Two, however all of the agencies continued to participate in the Initiative and many are taking active steps to address the blocks in systems and structures that are now more obvious.

The protocols are now also being used with agencies outside of the Initiative e.g. RIS and Keltoi. This is an extremely positive development and indications are that this is working very well. Youth organisations in Blanchardstown are also considering adapting the model to develop more seamless approaches in their work with young people. This is again a very positive development.

Funding has been accessed following a BLDTF application to the 'emerging needs' fund to develop protocols with agencies involved in treatment. The links between that and this Initiative, however, have not been worked through.

5.1.5 Conclusion

The main focus of this Phase was to embed the protocols in the agencies systems and cultures. Stated actions in the proposal extension plan did, in the main, occur and add value to the Initiative. The fit between the activities, however, and the objectives in the plan is not clear in all cases. There was a high level of inter-agency activity, particularly from agencies with a focus on rehabilitation, e.g. the RIS, LES and Coolmine TC. The protocols are influencing work with agencies outside of the Initiative and outside of the area. This is benefiting clients and expanding the use of the protocols to other relevant agencies. The levels of joint care planning and change of lead agency, however, were very low.

5.2 Factors that Contributed to Progress in Phase Two

5.2.1 Commitment

The extraordinary levels of commitment by the agencies involved in the Initiative contributed to the progress made in Phase Two. The Steering group members demonstrated ongoing willingness to work through the model developed in Phase One. This is despite many complex issues that had not been anticipated This commitment is all the more remarkable given the huge personnel change at all levels of the Initiative, which resulted in the vast majority of those involved in Phase Two being new to senior posts in the area and being uninvolved in the initial concept.

5.2.2 Protocols

The protocols worked well in Phase Two. While the agencies did not totally achieve the standards outlined, they acted as a benchmark for good practice.

5.2.3 Tracking

Despite the limitations of the system and the difficulties with implementation, the tracking system was extremely beneficial in establishing a quantitative baseline of information.

5.2.4 Independent Expertise

The Steering group benefited greatly from the external expertise of neutral and cross-agency personnel/consultants. They allowed questioning to take place in the Group. They assisted the development and maintenance of the Group, which was particularly important in re-establishing it during Phase Two.

5.2.5 Funding

The available budget enabled the Initiative to contract the required expertise to work with the group to support the cross-agency work.

5.2.6 Independence

The Steering group operated independently from other structures. This allowed them to have complete flexibility and autonomy. They did not work to any single agency's agenda, which aided this phase. This neutral ground enabled agencies to fully participate as equals. The DP did not interfere in the work of the Steering group: It acknowledged them as the experts in this phase of the Initiative and aided their progress.

5.2.7 Agencies and Staff

Blanchardstown has a particular range of agencies of which some are quite specific to the area e.g. BOND. It is also one of five areas with a Rehabilitation Integration Service run by the HSE. The commitment and expertise of particular staff within agencies was also evident. Some staff were particularly engaged in using the protocols and working with agencies to aid their clients' progression, e.g. the RIS are working very closely with particular CDT staff. It was evident from the client interviews that they are aware of a) the inter-agency approach used by particular staff and b) its positive affect on their progression.

5.3 Factors that Blocked Progress in Phase Two

The challenge of Phase Two (i.e. to embed a model of change) was very different to that of Phase One (i.e. to develop and test the change model). It is particularly difficult to sustain and implement change when it is not an 'easy fit' with the current organisation culture. It is also difficult to sustain the energy required to implement systemic change particularly when new, exciting opportunities to develop other pilot initiatives emerge. The following outlines the key factors that blocked progress in Phase Two:

5.3.1 Factors external to the Initiative

National Models

There is no agreement at national level on a) a rehabilitation strategy, b) a definition of rehabilitation or c) a treatment and rehabilitation continuum of care that maps the services needed at all points in the continuum. While some of these issues are currently being addressed, the agencies in this Initiative worked at local level without this framework. This impacted significantly on their progress.

The agencies involved lack clarity on the long-term future of this Initiative. As stated, it does not fit under any national rehabilitation strategy. It also has no resources to continue to development in the short or long term. In order for the agencies involved to develop the organisational systems and structures required, they need to be clear that this Initiative fits with national thinking and will be supported in the long term.

Treatment and Rehabilitation Services

The Blanchardstown area lacks progression options across treatment and rehabilitation. There are limited community or residential detoxification options for clients locally. For clients who have stabilised or become drug free, there are major deficits in tailor-made training and education courses that are run locally. These gaps are outlined in section 5.1.1. The serious gaps and problems with service provision in Blanchardstown make it very difficult to operate this inter-agency model.

Data and Information

The majority of agencies do not have easily accessible, accurate information and statistics. A local picture, therefore, of the numbers of drug users per service, their length of time with agencies, their current status (chaotic, stabilised, detoxifying, drug free) is not available. This impacts on the work of the Initiative as it is impossible: a) to determine how many drug users are ready to progress through rehabilitation using the protocols and b) the impact that using the protocols have made for clients. Data collection has, understandably, not been a priority for many agencies. Issues relating to data and information also had an impact on the development and implementation of the tracking system.

5.3.2 Factors within the Initiative

Personnel Change

Personnel change impacted enormously on the Steering group and the implementation of the Initiative.

a) Six of the eight agency representatives on the Steering group changed in Phase Two. This loss of continuity clearly hampered the work of the Group,
b) It was unclear if the HSE through RIS were the lead agency in Phase Two. At certain points, therefore, there was no one to take responsibility to drive, direct, hold the vision or link to other appropriate developments. This was particularly problematic because the RIS representative in Phase One was the chairperson and clearly led the Initiative. This type of leadership was named as a key aspect in the success of Phase One: It did not emerge in Phase Two,

c) The Co-ordinator moved on and the initial consultant engaged to carry out the tracking was not in a position to complete that task.

Systems and Structures

Although the agencies involved had extensive knowledge of each other's services, the Steering group lacked a detailed understanding of each other's systems, structures, management and cultures. Assumptions about each other were made when designing and implementing the inter-agency protocols and tracking.

In some cases, the systems and structures required for the inter-agency protocols and tracking were not in place or were not sufficiently robust, e.g. a) some agencies lacked good case management systems, b) the tracking relied heavily on internal client data systems that sometimes did not exist and c) inter-agency induction relied on relatively structured induction processes.

The implementation of the protocols also relied on staff management systems: where these were not in place, the protocols were not always implemented or were not implemented by all staff.

Progression Pathways at the Local Level

Section 2.3 highlighted the lack of an agreed national treatment and rehabilitation continuum of care. Combined with this, some agencies in the Initiative offered a very broad range of services to clients in a particular community area, i.e. they did not specialise in a particular part of the continuum. This type of service did not always fit well with the protocols, e.g. it was not always clear why they would relinquish the lead agency role, since they could work with the clients throughout the continuum.

Funding

The Steering group were disconnected from decision making in relation to the budget. The funding available in Phase Two was not maximised and therefore opportunities to develop the Initiative further were lost. Lack of control over the budget for the Initiative by those directly involved was a block to the most effective use of the resources available.

6. LEARNING FOR FUTURE INTER-AGENCY INITIATIVES

This section outlines the key learning from Phase Two of the Initiative.

6.1 Pilot versus progression to mainstream

There is a substantial difference between piloting the protocols and embedding them in agencies' systems and cultures. The voluntary and community and local development sectors, in particular, are very experienced in piloting innovative projects: this Initiative, however, involved extensive longer-term change for the agencies involved.

6.2 National impact

The need for national strategies and models to support the local Initiative became apparent in Phase Two.

6.3 Levels of service

Appropriate, well- resourced, service provision is required for service-level, inter-agency work. This is acknowledged in the draft rehabilitation strategy and the Bruce Report.[42] If service gaps are not addressed quickly, agencies, staff and clients become disillusioned, as the clients who are engaged in the Initiative have very few progression options.

6.4 Leadership

Leadership for inter-agency work is particularly important but also complex. It must take account of the competencies of the person to lead and the agency from which they come. It must also take account of their expertise and experience in the area, in inter-agency working and of the multiple agencies involved.

6.5 Systems and structures

Inter-agency initiatives of this type need to take into account the organisational systems and structures of their component agencies before carrying out the inter-agency process.

6.6 Protocols

Having clear, agreed, user-friendly protocols can act as a benchmark for best practice in working with other agencies.

6.7 Data

Having reliable, accurate data on the interventions and their impact on the individual client is essential.

6.8 Commitment and trust

Agencies need to be committed and open to working together to seek and implement solutions.

[42] Bruce, A *"Drugs Task Force Project Activity for FAS Community Employment Participants, A Review"*, July 2004.

6.9 Group development

Neutral or external facilitation helps agencies to participate as equals. It assists in developing the teamwork required. It works best alongside internal leadership and consistent, committed active participation by all agencies.

6.10 Client input

The need for ongoing consultation with clients became very clear in Phase Two. The interviews with clients not only allowed this Initiative to gather information on how the protocols were working for them, but also to gather their insights into more general gaps in services and in the quality of services on offer. This feedback has already impacted on the services involved in the Initiative.

6.11 Resources

The agencies need adequate resources to work together, to innovate, to develop materials/programmes, to train staff, to hire neutral venues and to contract expertise. If this innovation is key, it must be resourced. Agencies need to have direct input into all financial plans and be consistently involved in monitoring spending with a view to maximising available funding. Flexibility is required from funders to enable funding to be re-directed to respond to changes that emerge that affect initial plans.

6.12 Overall

This is a highly innovative and ambitious Initiative in inter-agency working at a local service level.

The agencies involved have displayed huge commitment to it over the past three-and-a-half years. In Phase Two, this commitment was seriously tested as the levels of personnel change, which could not have been anticipated, came at a time when substantial changes were demanded from the agencies involved. Despite this, commitment to the Initiative from new senior management in the area continued to be strong.

Although Phase Two was very challenging, the agencies involved were willing and able to engage in the process. Inter-agency working has increased substantially in Blanchardstown. Staff have an increased knowledge of the services involved, they are using the protocols, and referral levels are very high. New service approaches have emerged, e.g. LES provides a more structured service to Coolmine TC. Clients that were interviewed are aware of and open to working with different agencies at different stages of their rehabilitation. They saw the value for them in agencies working together using the agreed protocols.

Inter-agency activities are happening between some agencies outside of the protocols. The protocols are being used by the agencies in their work with others outside of the Initiative. These are all very positive developments. Embedding the protocols has proved a bigger challenge for some agencies than others. Agencies are using the lessons learned through this Initiative, however, to change, develop and adjust their services e.g. considering changes in how services are offered to clients, re-examining staff roles. This is extremely important, as Phase Two of the Initiative has caused the agencies involved to reflect on the current service provision and to take active steps to improve the level and quality of services for drug users in Blanchardstown: it is unlikely that this would have happened in the absence of this Initiative.

7. RECOMMENDATIONS

This section makes a series of recommendations for those involved in this particular Initiative and for national policy makers to consider.

7.1 Blanchardstown Inter-agency Initiative

7.1.1 Challenge of Continuation

It is clear that this Initiative should be continued. In the light of the challenge posed by the external environment, however, the agencies involved in the Initiative will need to consider their level of commitment into the future. The issue of leadership and co-ordination are particularly important in this regard.

Neutral facilitation and personnel dedicated to cross-agency work would be helpful in furthering this work. One approach would be to have seconded staff working with external consultants.

7.1.2 Services

Very significant service gaps have been identified through the implementation of the Initiative (the identification of service gaps was one of the aims of the original Initiative). There are particular gaps in terms of stabilisation, detoxification and rehabilitative training and education courses.

It is essential that these service gaps be filled as a matter of urgency: otherwise, it will hamper the central objective of expediting and facilitating client progression through inter-agency co-operation.

Pilot projects underway or shortly to be introduced such as "Right Steps" training programme and "Bridge to the Workplace" need to be evaluated and, if appropriate, made permanent.

Coolmine TC has put a provisional proposal forward for a stabilisation programme in the Blanchardstown area. This should be given full consideration.

Services need to be carefully tailored to the specific needs of the client group.

Taking action on identified problems needs to happen more quickly, e.g. the service gap in first step training came to light in Phase One of the Initiative in 2004 but the pilot "Right Steps" training programme will only commence in October or November 2006.

It is essential that meaningful client feedback play an important role in the development of services.

Given the feedback gathered from clients during the tracking review and this evaluation, those involved in the Initiative should consider whether or not clients at different stages of progression require separate service environments.

7.1.3 Inter-agency Working

In order for the inter-agency protocols to operate effectively, it is essential that assessment, planning, case management and staff management are in place: there must be a common understanding of what these terms mean between the different agencies. At present, there is clearly a divergence between the agencies on these systems and on what they understand by these terms.

Very few clients have changed lead agency. The factors that have led to this needs to be identified and reviewed. RIS clearly plays a crucial role in progression and, theoretically, would be an obvious lead agency for those moving on from other services. The RIS service remit, however, and its resources need to be reviewed in this context.

7.1.4 Monitoring and Tracking

Consideration should be given to tracking and monitoring a small group of clients: this could work through the issues and problems and identify what is working well. This pilot could also inform the broader tracking process recommended and could be used to develop case studies to demonstrate the work of the Initiative and to motivate staff to actively use the protocols in their work.

7.1.5 Agencies and projects outside of the Initiative

The agencies in the Initiative should consider adopting the protocols in dealing with those agencies most frequently referred to outside of the Initiative (including agencies who provide ancillary rehabilitation needs such as accommodation). RIS are already adopting this approach. It would, however, clearly not be feasible to bring all of the key agencies that work with the agencies into the Initiative.

The agencies developing the Treatment protocols should consider the learning and recommendations outlined in this report. Dovetailing the work of the Treatment and Rehabilitation Initiatives would be of great benefit.

It would be useful to identify comparable projects elsewhere in Europe and the US, and to learn from these. The connections that new managers in Phase Two have with projects in the UK, and links made by the Blanchardstown Equal project to other Equal funded projects in Portugal and the UK, could act as a basis from which to learn.

7.1.6 Evaluation and Review

Given the innovative nature of the Initiative, it is important that there is an ongoing process of evaluation and review.

7.2 Funders and Policy Makers

7.2.1 Support and resourcing the Initiative into the future

This Initiative has proved to be an effective laboratory for testing innovation in inter-agency work at the delivery level. It has also delivered real improvement in client services. This Initiative has the potential to contribute significant learning for policy makers and administrators who are grappling with the difficulties of inter-agency work.

7.2.2 Rehabilitation strategy

The rehabilitation strategy should incorporate the learning from this Initiative, including blockages that have been identified. An agreed continuum of treatment and rehabilitation is required.

7.2.3 Status of the Initiative

Given the investment by the agencies involved in the Initiative, it is important to clarify the status of the Initiative within the context of broader strategies.

7.2.4 Mainstreaming

The current gaps in ongoing support, in development and in monitoring of mainstream-funded projects need to be urgently addressed.

7.2.5 Lead agency

Clarity is urgently needed on the leadership of this Initiative.

7.2.6 Administrative inconsistencies

Current resource allocation models, policies and administrative mechanisms within the agencies can cut across the work of the Initiative, e.g. current resource allocation models are based on numbers of clients whereas a key objective of the Initiative is that agencies should hand over appropriate clients to other agencies.

7.2.7 Tracking and monitoring

Client tracking is obviously extremely important: the effectiveness of the work of the agencies and the inter-agency work cannot be gauged without it. The creation of an effective tracking mechanism, however, is a major undertaking that needs to be put in place at national level. The Initiative could be used to inform the design and as a pilot.

7.2.8 Review and development

A review of the systems in place in the agencies in the Initiative would have helped to avoid some difficulties that arose, e.g. the Client Tracking system put some of the agencies under strain, as they did not have existing systems in place (see Recommendation 7.1.4). If elements of the Initiative were to be mainstreamed, such system reviews should be carried out as a matter of course.

Support should be given to those agencies that are changing partly as a result of this experience. For example Coolmine TC requires funding to expand and develop its' services, some CDTs are considering issues such as developing specific expertise within staff and changing how their services operate.

8. ACKNOWLEDGEMENTS

The evaluators would like to offer sincere thanks to everybody who participated so generously in this evaluation process.

We would particularly like to thank the clients who took part in the interviews.

We would also like to thank the Steering Group and the staff from the agencies who participated, particularly as it involved giving time above and beyond their main work. The range and detail of the issues dealt with in this evaluation reflects the creative and innovative nature of the Initiative and the high level of commitment of those involved in it.

APPENDICES

Appendix One: References

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Appendix Two: Four-Tier Model of Treatment [43]

This outline of the four tier model of treatment is taken directly from the "Report of the Working Group on the Treatment of Under 18 year olds presenting with drug problems", September 2005, Pages 45-47. It is proposed as a model for working with young people.

Tier One

Tier One comprises services which have contact with young people but who do not have specialist expertise in either adolescent mental health or addiction. In essence these are generic services such as education, youth and family services having direct access to young people and are suitable places to provide certain front-line interventions. Those involved include teachers, social services, police, probation and welfare, primary care service providers, community and family groups. The services provided for the general population of young people include substance misuse education, information and referral to support services. The type of adolescent accessing these services would be those considering or commencing experimentation with drugs or alcohol.

Tier Two

Tier Two comprises services, which have specialist expertise in either adolescent mental health or addiction, but not both. By their nature they will be in a position to offer some supports to young people who may be vulnerable to drug misuse problems. The people involved include GP's trained in addiction, Juvenile Liaison Officers, Local and Regional Task Force projects, home school liaison, youth homelessness services, Youthreach and drug treatment centre staff. The services provided for vulnerable young people include drug related prevention and targeted education, advice and support and counselling. The type of adolescent accessing this service would be those who are abusing alcohol or drugs and encountering some problems as a result.

Tier Three

Tier Three comprises services that have specialist expertise in both adolescent mental health services and addiction, i.e. multidisciplinary teams comprising people with a speciality in adolescent addiction. The essential feature of Tier Three is the co-operation of services to provide child centred comprehensive treatment to young people presenting with serious drug problems. It is the bringing together of the multidisciplinary team which provides the necessary expertise in adolescent addiction through the particular expertise of individual members. Not all individuals in the team will be experts in adolescent addiction: indeed many if not most may be working part-time in Tier Two services.

A Tier Three team must have access to the competencies needed to deliver such services, including access to expertise in the following:

- Medical treatment options for addiction disorders (e.g. child psychiatrist or psychiatrist registrar or GP),
- Treating co-morbid disorders (e.g. child psychiatrist or psychiatrist registrar),
- Expertise in child protection issues (e.g. social worker),
- Outreach (e.g. experienced outreach worker),
- Assessment of development issues (e.g. child psychiatrist or psychiatrist registrar, clinical psychologist),

[43] Taken directly from *"Report of the Working Group on the Treatment of Under 18 year olds presenting with drug problems"*, September 2005, Pages 45-47.

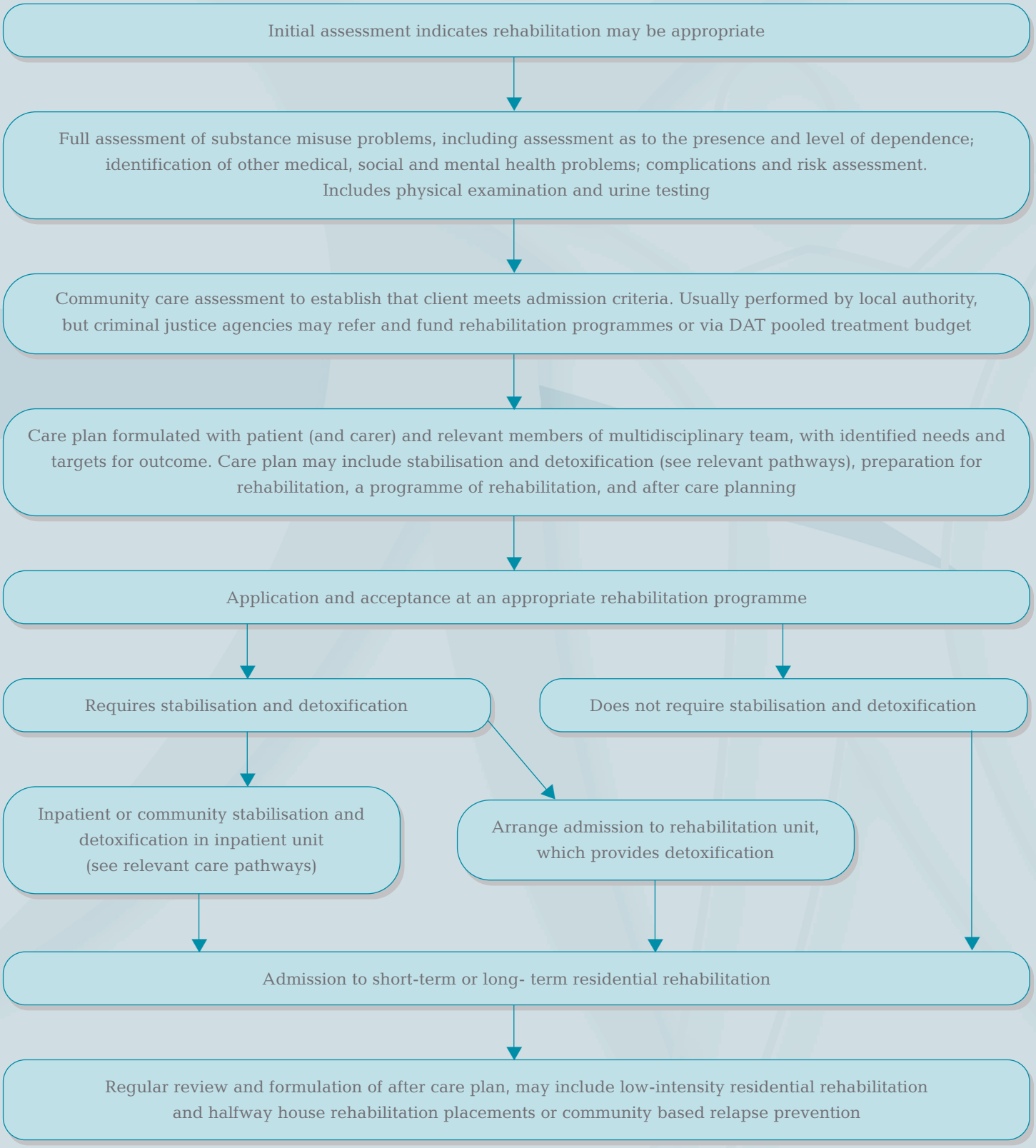
- Delivering individual and group psychotherapeutic interventions (e.g. clinical psychologist, child or addiction counsellor or nurse or child-care worker),
- Expertise in systemic/family therapy (e.g. family therapist).

The type of adolescent accessing this service would be experiencing substantial problems secondary to drug or alcohol abuse, or experiencing drug or alcohol dependence. Within this context, the group stressed the value of a key-worker maintaining an on-going relationship with the client throughout his/her period of care.

Tier Four

Tier Four services have specialist expertise in both adolescent mental health and addiction and the capacity to deliver brief but very intensive treatment, e.g. in-patient or day hospital. At present these services are provided in Cuan Dara, The Drug Treatment Centre Board, etc. The type of adolescent accessing this service would be experiencing drug or alcohol dependence with service associated problems.

Appendix Three: Sample Continuum - Care Pathway for Residential Rehabilitation[44]



[44] Taken directly from NHS briefing on four- tier service

Appendix Four: EQUAL Expenditure Phase Two - June 2005 to August 2006

Budget Available	
ESF	€116,755
Match Funding	
a) Cash	
BLDTF (Emerging needs Fund)	€10,000
HSE	€5,000
c) Participating Agencies (Benefit-in-Kind)	€3,904
Total	**€135,659**

Heading	Budget Allocation	Expenditure	Under spend	Over spend
Trainer, personnel, room hire	16,625	14,533	2,092	Nil
Premises, equipment, material	5,817	2,290	3,527	Nil
Administration and general overheads	75,313	62,333	12,980	Nil
Tracking report and evaluation	19,000	20,630	Nil	1,630
TOTAL Spend	**116,755**	**99,786**	**18,599**	**1,630**

Appendix Five: Steering group Members Phase Two

Ingrid Colvin	Blanchardstown Offenders for New Directions	Member Phase One
Joseph Doyle	Blanchardstown Local Drugs Task Force	Member Phase One
Niamh Moynihan	Health Service Executive, RIS One	Member Phase
Marie McKay	Mulhuddart Corduff CDT	Member Phase One
Ger Supple (Chairperson)	Mountview Blakestown CDT	New member
Paul Conlon	Coolmine Therapeutic Community	New member
Elaine Moore	Hartstown Huntstown CDT	New member
Noel O Connor	Tolka River Rehabilitation Project	New member
Mary Tighe	Local Employment Service	New member

Appendix Six: DP Members Phase Two

Michael McCabe	Blanchardstown Centre for Independent Living Member Phase One (Chairperson)
Gerry Keogh	Local Employment Service Member Phase One
Brian Santry	Probation and Welfare Service Member Phase One
Terry McCabe	Blanchardstown Area Partnership Equal Co-ordinator Phase One and until February 2006 of Phase Two. Was previously on the DP in her role as Co-ordinator
Helen Purcell	Blanchardstown Area Partnership New member
Joseph Doyle	Blanchardstown Local Drugs Task Force (Steering group representative) New member
Ingrid Colvin	Blanchardstown Offenders for New Directions New member
Niamh Moynihan	Health Service Executive RIS New member
Gerry Carrigg	Fingal County Council New member