DRUG POLICY Action Group

Re-thinking Drug Policy in Ireland

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SOCIAL CARE & DRUG USERS IN IRELAND

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Policy Paper 2
SOCIAL CARE & DRUG USERS IN IRELAND

By
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Drug Policy Action Group

The Drug Policy Action Group aims to promote an approach to drug policy that challenges ineffective, unfair and counterproductive laws on drugs, and advocates for positive health and social service responses to drug use in Ireland. It also seeks to progress effective evidence based treatment models that engage drug users, families, and communities in the reversal of the harms associated with problem drug use[1]. One of the main objectives is to promote the development of high quality information and education on drug use and drug policy, in doing so a series of policy papers have been compiled. This paper examines and contextualises problematic drug use within existing social care structures.

Introduction

1.1 This paper examines the provision of formal i.e. specialist treatment services & drug agencies and generic social care services for problem drug users in Ireland. It will be seen that problem drug users (such as Jim and John), and people affected by the drug use of others, are a significant part of the workload of social care service providers. In many cases there will be a number of health and/or social care workers engaged in meeting the multiple and often inter-related needs of this client group. All too often there is a failure by social care services to recognise and/or provide for the inter-connected nature of drug users' needs. Services tend to focus on individuals 'single need' (be it treatment, accommodation/housing, mental health care or employment/ training) in isolation from the rest of their life.

1 A problem drug user is "any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and dependence, as a consequence of his or her use of drugs or other chemical substances" ACMD (1982) Report of the Advisory Council on the Misuse of Drugs. The Stationery Office. London.

Setting the Scene

2.1 For a large majority of people, social care is provided primarily by family, friends, and/or neighbours, through informal networks of mutual support. However, the state plays a vital role in supplementing such care though the provision of public health services, public social care services, and other services such as education, employment and housing, typically accessed in times of crisis. Voluntary organisations (NGOs) have a longstanding tradition of providing the main conduit of formally organised care in Ireland, supplementing the informal care of family and friends. The voluntary sector's role (& increasingly the private sector's) is considered essential in the current 'mixed-economy' of social care in Ireland.

2.2 Social care services are as diverse as the clients they support. The services include supporting children and families, providing long-term care for the elderly, as well as providing services for people with learning disabilities, mental health issues and drug and alcohol problems. Social care services are for everyone; at some point in their life everyone may need to avail of social services. Thus, social care needs to be readily available to all, although some people will have a more sustained need for care and support, in particular those with multiple or 'complex' needs, while others will never need to avail of such services. Therefore, social care services may be considered universalist rather then universal, as they are not universally experienced.

Jim's Story

JIM, aged 18, has been using drugs for the past five years. He blames his father, who sexually abused him during his pre teenage years. Jim left home when he was sixteen and has been living in homeless hostels ever since with his drug use becoming apparent. Homeless service provision was his first point of service contact. He accessed treatment services, and was put on a methadone maintenance programme with his local GP and he started attending a FAS course. Recently Jim's mother died, and he was heartbroken. He began using heroin again and added cocaine to his daily fix. He stopped going to his FAS course. He now had no money, as he was deemed ineligible for social welfare assistance because he had left the FAS course 'of his own choice'. He started robbing to get enough to eat and to pay for his heroin. He was arrested and had to attend court. After a few weeks, Jim's GP stopped his methadone maintenance because of his continued heroin and cocaine use. The hostel he was in threw him out because it did not tolerate heroin use. When his mother died, he stopped attending the counsellor for his childhood sexual abuse. Jim took an overdose and was brought unconscious to hospital where his life was saved.

John's Story

JOHN has a drug problem and desires to overcome it. With the support of his counsellor he accessed a place in a detoxification centre. On completion of his detox John had to wait for a place to become available in a residential drug treatment centre and, while waiting, he was forced to return to his community where drugs are readily available and where he is in grave danger of relapsing. On completion of the residential drug treatment programme, John again had no safe place to live: he had to return to a home where his brothers were using drugs. He was out of work and had nothing to do all day long - one of the strongest factors which can propel a person back to drug use. The drug detox centre did an excellent job; the drug treatment centre did an excellent job. But nobody was addressing John's housing and training needs. The Local Authority placed him on a waiting list; as he is single, with no children, there is a ten-year waiting list. To the Local Authority, John's housing need is not urgent as he has a place that he can physically occupy; but to John, his housing need is critical to his recovery. To FAS, he is considered a low priority, and hard-to-place (because of his prior drug history) but to John, useful occupation during the day is again critical to his recovery. The failure of services to address his housing and training needs puts John's recovery seriously at risk. Prior to going into treatment, John ran up significant debts with his local drug dealer who will, as soon as it is known that John is back in circulation, come knocking on his door demanding payment within 24 hours.

Social Care Services for & Utilised by Drug Users

3.1 The main social care services accessed by and providing services for problem drug users are specialist drug treatment services and drug agencies. Problem drug users, particularly those with a range of needs often present at other health care and generic social care services, which can cause uncertainty regarding what responses are required, and hence what agencies/services are involved. The role of these key services in working with drug users will be briefly outlined.

3.2 The main social care services provided specifically for, and accessed solely by, problem drug users are specialist treatment services, and drug agencies. As the number of problem drug users increased in Ireland over the last 25 years, a broad range of specialist services and agencies have evolved to meet their needs. The lack of an agreed service model for specialist drug treatment provision, and variation in the scale and pattern of problem drug use from area to area, means that different health board regions, cities, and communities provide combinations of services, usually including both statutory and voluntary provision. Consequently, there are large variations in the types of services available to drug users with contrasting approaches to the care of this client group, often reflecting differing theories on problem drug use and addiction, and differing perspectives on how people can best be treated. The most comprehensive range of services are provided in Dublin; other cities in the country do not offer such an extensive array of services, primarily due to the relatively recent onset of problem drug use. A broad range of staff are involved in providing specialist treatment services for problem drug users including medical staff, social workers, counsellors, and generic drug workers.

However, it is recognised that a large proportion of problem drug users have mental health problems which remain undiagnosed

3.3 Problem drug users access a range of other health care services such as GPs, hospital A & E departments, and outpatient services, although there are limited data available on the extent to which they utilise these services in Ireland. The relatively high levels of HIV, hepatitis B and C infection among intravenous drug users in particular means that many have to access GUIDE (GenitoUrinary Medicine and Infections Disease) clinics, and other specialist units. In addition, the high levels of mental health complaints among problem drug users, and incidence of dual diagnosis, means that some do access mental health services. However, it is recognised that a large proportion of problem drug users have mental health problems which remain undiagnosed.

3.4 There is a complex, yet clear link between unemployment and problem drug use. In that, problem drug users tend more often than not to be unemployed, and there is a high rate of problem drug use among the unemployed. Unemployment is unlikely, on its own, to be a major determinant of the onset of problem drug use. Yet there is undisputable evidence to support the fact that employability is a major factor in preventing relapse. Work provides a sense of responsibility, personal value, independence, security, dignity and a stake in society. Moreover, employment's 'therapeutic' potential is inherent in definitions of rehabilitation, as a process of restoring function and reintegration into society. Yet enhancing the employability of drug users has not traditionally been a priority for treatment and rehabilitation services, where the clinical goals of abstinence or stability and maintenance are generally given priority. This is the case, even though many problem drug users, in particular those in treatment, have been out of employment for some time. So there is undoubtedly an interaction between unemployment and drug problems; with the causal balance shifting in the same person at different times, across different people and in different social and economic contexts. The high rates of unemployment among problem drug users in Ireland indicate that many come into contact with national training and employment agencies.

3.5 Income is a crucial aspect of social care. Due to the high levels of unemployment among problem drug users, particularly among those in treatment, many are in receipt of social welfare benefits. While some may not be actively seeking employment, the treatment system, in particular methadone programmes, are not always able to facilitate clients taking up employment due to restricted opening hours and staffing. Thus, services may be at risk of underestimating the therapeutic role of employment. A sizable proportion of problem drug users are on disability allowance, primarily individuals who have been diagnosed HIV and/or HCV positive.

3.6 Housing is more than simply providing a roof over someone's head. It is also about providing security, privacy, sufficient space, a place where people can grow, make choices, and become more whole. Decent housing is essential for a good quality of life, socially, emotionally and physically. Moreover, housing is a vital component of social care, and often the key to independent living. Structural forces in housing policy have resulted in the concentration of socially excluded groups in low quality social and increasingly private sector housing. For many problem drug users, family and friends provide the main form of social care regarding housing. However, living in the family home does not always work out, and therefore, it cannot always be considered stable, suitable housing. The relationship between social deprivation, poor housing and/or homelessness and problem drug use has long been recognized (although the causal direction of the relationship is complex).

Defining Complex Needs

4.1 As highlighted above, it can be argued that we all have multiple needs; we all need a secure source of income, a suitable place to live, meaningful activity and social interaction. However, increasingly the term 'complex needs' is being used as a framework to help policy makers and practitioners to understand the inter-connected nature of people's needs, rather than using overtly prescribed definitions (such as 'dual diagnosis'). Turning Point defines people with 'complex needs' as individuals

"…with multiple interconnecting needs that span medical and social issues. Individuals with 'complex needs' may have mental health issues, combined with substance misuse problems, and learning disability. At the same time they may experience social exclusion, such as living in poor housing, with few opportunities for meaningful activities and leisure". [2]

People with complex needs can be seen as lying at one end of a continuum; they are vulnerable persons who have multiple and usually intractable problems and seek their solution by attending a number of agencies on many occasions. At the other end of a continuum; are those who have simple 'single' needs, who present at one agency with one problem.

4.2 Fundamental to the definition of 'complex needs' provided by Turning Point is that there is no typical case. It suggests multiple, interlocking problems, where the total represents more then the sum of the component parts. In addition, it recognises that people have physical, social, and emotional requirements and that their

2 Rankin, J. & Regan. S. (2004) Meeting Complex Needs: The Future of Social Care. Turning Point & The Institute of Public Policy Research: London.

needs are closely related to, and influenced by, environmental factors in the wider community, such as poverty, deprivation and social exclusion. Perhaps more importantly, it acknowledges that not only is there a range of needs, but also a level of need. In other words, needs have both breadth and depth, and all too often the depth rather than the range of need determines whether an individual receives treatment.

Drug Users & Complex Needs

5.1 Drugs workers, service providers, researchers and policy makers are well aware of the fact that the majority of problem drug users in treatment have complex needs. A high proportion of drug users have multiple problems ranging from psychological (ADHD, panic disorder, depression) or serious mental health problems (schizophrenia), to severe employment and economic problems, poor living arrangements, familial and social relationship difficulties, and/or legal problems. In addition clear links have been established between mental health problems, problem drug use and crime. The diverse range of complex needs, and interconnected problems facing many drug users are best illustrated by referring to the earlier case studies.

Housing is more than simply providing a roof over someone's head

5.2 As portrayed in the first case study, Jim is a young man with complex needs in so far as he has multiple and interconnected needs, that span health, familial, housing, employment and legal issues. How did the social care system respond to Jim's needs? Jim was sent to his local GP who put him on a methadone programme. He was sent to a voluntary organisation for counselling for sexual abuse. He was sent to a drug counsellor to address his problem drug use. He was sent to FAS to secure a training course. He was sent to the Homeless Person's Unit to access accommodation. He was sent to a bereavement counsellor when his mother died. He was sent to the social welfare when he had no income. He was sent to the courts when he was caught robbing. He was sent to a psychiatrist when he overdosed. Each individual service targeted a particular need. Each service had its own definitions and labels, which established strict boundaries for the work that they undertook. Each service focused on one of Jim's problems separate from the rest of his life. There is no question that each did an excellent job within their remit. However, the inability of the social care system to provide Jim with an integrated or sustained pathway of care resulted in him accessing a range of uncoordinated services, at different points in time, each one operating in isolation.

5.3 The second case study highlights the failure of the social care system to adequately provide for John's (life threatening) needs, needs which he cannot address himself and may force him into crime to pay off the debt. Either way, John's decision to end his drug using career is seriously eroded. Despite a large amount of public money, and dedicated staff invested in assisting John to become drug free, the lack of joined-up work within social care services substantially increased his risk of relapse.

5.4 As seen in John and Jim's story, the absence of a continuum of care model, means that vulnerable members of society who have the most complex needs, are more likely to fall between the gaps in services. Health and social care services in Ireland were designed to meet single, rather than multiple, complex needs. Each specialist service has developed a fixed idea of what constitutes their 'core business'. The isolation of services can cause individuals with complex needs to experience a sense of frustration, as they are not getting the help that they need. Moreover, this client group often experience the services they access as being "unhelpful"; while those who work in the relevant services often experience this client group as being "hard to help" and/or "not our problem". On the other hand, services experience a sense of frustration in their inability to respond adequately to needs beyond the remit of their organisational structures.

Factors Influencing Positive Engagement with Social Care Services

6.1 Over the last twenty years a large body of evidence has been gathered demonstrating that a wide range of interventions and service components are effective in reducing drug use, the associated health risks and criminal activities. While there are still gaps in our understanding of what works best for whom, and why, to maximise service efficacy and decrease the impact of drugs on the wider community, it is considered appropriate to be able to offer problem drug users a wide range of evidence-based interventions and service delivery components. The approaches that work best for one person will not necessarily work for another. Moreover, the complex nature of problem drug use means that drug users often require different combinations and levels of service delivery over time and consequently require continuous support.

6.2 Research indicates that the factors that are most likely to lead to positive service engagement across social services are (i) rapid in-take, (ii) systematic assessment & service tailoring, (iii) a comprehensive approach to care management, (iv) retention in service and (v) interagency coordination.

RAPID INTAKE: Many drug users present to services in crisis when they are extremely vulnerable. Anything less than an immediate response can be a setback, can reduce an individual's motivation, and make approaching services ever harder in the future. Furthermore, research shows that early engagement after first contact can increase retention in services.

SYSTEMATIC ASSESSMENT & SERVICE TAILORING: Research shows that generally, the more services are tailored to client needs the longer they stay engaged and the greater the outcomes. More specifically, it is not just whether housing, employment or other 'needs' are resolved by the an individual service that improve retention and outcome, rather that the service plays an effective part in the resolution, follow-up and referral of presenting needs.

A COMPREHENSIVE APPROACH TO CARE & CASE MANAGEMENT: Problem drug use is often associated with other problems, underlying the need for a comprehensive care management approach, which attends to individual's multiple needs and secures a pathway approach to social care provision. Therefore, care plans are essential, with clear goals, both short term and long term, which should be reviewed on a regular basis.

RETENTION IN SERVICE: Retaining service contact has been shown to improve individual's social care outcomes. A number of factors contribute to poor retention, including prolonged assessment procedures, inflexible approaches to organisational policies, the lack of ancillary services, and poor rapport between service users and service providers. Conversely, delivering services within a positive supportive environment encourages people to stay engaged.

INTERAGENCY CO-ORDINATION: The complex nature of drug dependency means a client may require varying combinations of services and interventions during the course of their lives. In practice, this may involve a wide range of specialised and generic services working together to support individual clients. Consequently, close interagency co-operation in addition to an

effective care management system is crucial in order to prevent clients falling between services, to avoid the duplication or omission of interventions, and to ensure continuity of care.

Conclusion

7.1 In conclusion, the separate specialist social care model that currently exists in Ireland fails to provide for the complex nature of drug users' needs. Individuals invariably receive a series of single interventions often with incompatible treatment methods, by a range of services operating in isolation, where the sequence of care is often arbitrary. As a consequence, rather than receiving a single targeted intervention to meet their whole needs, drug users often experience an unpredictable and repetitive journey around different services. Furthermore, this 'separate specialist mentality' can foster a 'not our problem' perspective among service providers, confusing a continuum of care with referral for specialist treatment.[3] A 'one size fits all approach' to the provision of social care for drug users with complex needs is ineffective. All attempts to get a heterogeneous group of people (such as problem drug users) with a wide range of needs to fit into an inflexible social care system, poses challenges and limitations. A holistic, targeted, flexible response planned and agreed by social care services is more likely to meet the complex needs of problem drug users.

7.2 The reality is that social care services are often poorly coordinated; both across drug services and agencies and between drug services/agencies and other generic social care services. Moreover, there is little evidence of a three-way link between social care, health and housing agencies. A specialist drug treatment system has evolved which is largely divorced from other social care services, which has an adverse effect on coordination of care. Therefore, many clients fail to receive a seamless service, due to lack of coordination between different services, and poor joined up working with other services such as mental health. It is crucial that different treatment services are effectively co-ordinated and that appropriate support is marshalled from a wide range of other agencies, such as housing and mental health.

7.3 Across agencies there is a lack of understanding of other agencies, their roles, responsibilities, boundaries between them and the constraints each are working within. Organisations are often unsure of the services provided by, and personnel within, other agencies. While collaboration often occurs at a grassroots/staff level (often based on relationships built over time) there is little recognition or planning afforded to the development of coordinated approaches to work at a strategic organisational level. In addition, there are general difficulties in communication and sharing information at the level of service delivery between agency workers.

3 Miller (2002) "Is treatment the right way to think about it" in Miller, W. & Wessner, L. Changing Substance Abuse Through Health. Kluwer Academic/Plenum Publishers: US

Jim's Story

JIM, aged 18, has been using drugs for the past five years. He blames his father, who sexually abused him during his pre teenage years. Jim left home when he was sixteen and has been living in homeless hostels ever since with his drug use becoming apparent. During the review of Jim's care plan in the hostel, his key worker referred him to the young persons programme for an assessment. Jim was highly motivated at this time, and a coordinated assessment between drug and homeless service providers in consultation with Jim ensured a tailored based service intervention with appropriate actions. One of the identified actions in his treatment care plan was to engage in a FAS course. While on this programme Jim's mother died. The support structures established allowed for an early identification of Jim's relapse, and for his continual engagement in the FAS course. However, Jim found it very difficult to remain in a hostel with active drug users; this was brought up at a key worker session. In response a place was made available for Jim by another service provider in order to access more secure supported accommodation near his extended family. This service provider required assurances from both homeless and drug service providers that Jim was suitable for placement. Three-way meetings (drugs, homeless service providers and housing association) were initially established with Jim. These meetings are ongoing although have decreased in frequency and if all goes well secure accommodation will be a real possibility for Jim in the future.

John's Story

JOHN has a drug problem and desires to overcome it. With the help of his counsellor he accessed a place in a detoxification centre. Before completion of his detox, an assessment of John's housing needs were undertaken to ensure that John would not be exposed to any unnecessary risks that may contribute towards his relapse. It was here that it was highlighted that John was not on a local authority housing list, had a drug using home environment and had built up considerable debts from a drug dealer in the area. It was agreed that additional support was required in terms of residential drug treatment and once again highlighted the risk of returning home to his local area on his remaining drug free. As a result, a referral was made to a housing association in a different locality whereby floating support was provided that enabled him to begin independent living but while recognising the support structures in place. Having a secure address enabled John to gain part-time employment which provided him with sense of purpose and determination each morning when he woke up. This, he maintains was one of the strongest factors which helped him to remain drug free and not propel him back into drug use. The drug detox centre did an excellent job; the drug treatment centre did an excellent job. More importantly, it was that these services also looked at the importance of his housing circumstances and the association of having secure housing with remaining drug free and securing employment. While living with the housing association, it was explained to John the importance of maintaining his contact with the Local Authority. His drug free status, experience of independent living, current employment, early registration and constant contact with the local authority has meant that he is now in a position to access local authority housing in three years.

Key Citations

Miller (2002) "Is treatment the right way to think about it". In Miller, W. & Wessner, L. Changing Substance Abuse Through Health. Kluwer Academic/Plenum Publishers.

Rankin, J. & Regan. S. (2004) Meeting Complex Needs: The Future of Social Care. Turning Point & The Institute of Public Policy Research. London.

The Drug Policy Action Group
RECOMMENDATIONS

The DPAG recommends the following in relation to the social care of drug users in Ireland

1. The DPAG recommend an understanding of 'complex needs' which takes into account that each separate need interlocks with all of an individual's other needs and cannot be adequately addressed in isolation from those other needs.

2. The DPAG recommends that social care providers prioritise the importance of, and agree upon a strategy to develop a strong organisational commitment to interagency work, which collectively will enhance the provision of social care services in Ireland.

3. The DPAG recommends that the development of an interagency strategy to provide accessible entry to and retention within and across social care services in Ireland.

4. The DPAG recognises the importance of service user involvement in the development and implementation of existing and emerging models of social care delivery for problem drug users.

5. The DPAG believe that a published national audit of social care services/agencies is a necessary first step towards highlighting the current state of affairs, progress made and necessary improvements.

The Drug Policy Action Group believe that if a commitment is given to the aforementioned recommendations benefits will occur at policy, organisational and service user levels.

The DPAG offers the reader an opportunity to visualise and realise the impact of the recommended actions on the lives of service users, such as Jim and John.

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FR. PETER MCVERRY SJ was ordained as a Jesuit Priest in 1975. While working as a priest in the Inner City in Dublin, he encountered some homeless children and opened a hostel for them in 1979. He subsequently opened three more hostels, a residential drug detox centre, and two drug-free after care houses. He has written on many issues relating to young homeless people, such as accommodation, drugs, juvenile justice, the gardai, prisons and education. In 2003, he produced a book of his writings, called "The Meaning is in the Shadows".

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