Role of Special CE Places in an Overall Drug Rehabilitation Framework

1. Introduction

The overall objective of the National Drugs Strategy is to reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment/rehabilitation and research. Within this overall objective, one of the aims of the strategy is to enable people with drug misuse problems to access treatment and other supports in order to re-integrate into society. In this context, rehabilitation may be described as a facilitative process which aims to enable individuals who are disadvantaged in terms of accessing life in the mainstream to access as independent a life as possible in terms of their health and their social, cultural and economic well being. In 1997, FÁS earmarked 1,000 special CE places to support projects whose aim is to assist drug users to engage in training programmes that assist in their rehabilitation while also providing them with training for employment. The purpose of this paper is to describe the role of that intervention within the wider context of an overall drug rehabilitation framework.

2. Progression Path to Rehabilitation

Figure 1 below illustrates a progression path for individuals who are misusing drugs towards recovery and re-integration into society.

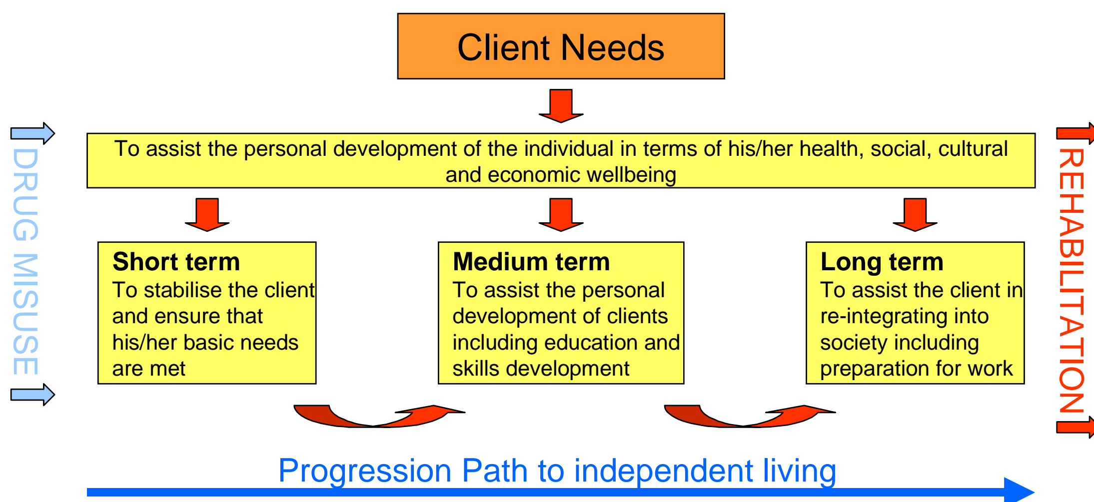


Figure I

While figure 1 reflects a model progression path towards recovery and re-integration into the mainstream, it must be remembered that drug misuse is a complex, psychosocial phenomenon. Accordingly, there is no single rehabilitation model which suits all individuals. A range of factors will affect the individual's progression towards recovery, with relapse and recidivism a familiar feature of the process.

3. Supports to Assist Rehabilitation

Bearing this in mind, the model identifies 3 broad phases which the individual must negotiate if he or she is to complete the rehabilitation process. A diverse range of supports are required to assist the individual in negotiating the 3 phases. These are set out in Figure 2 below.

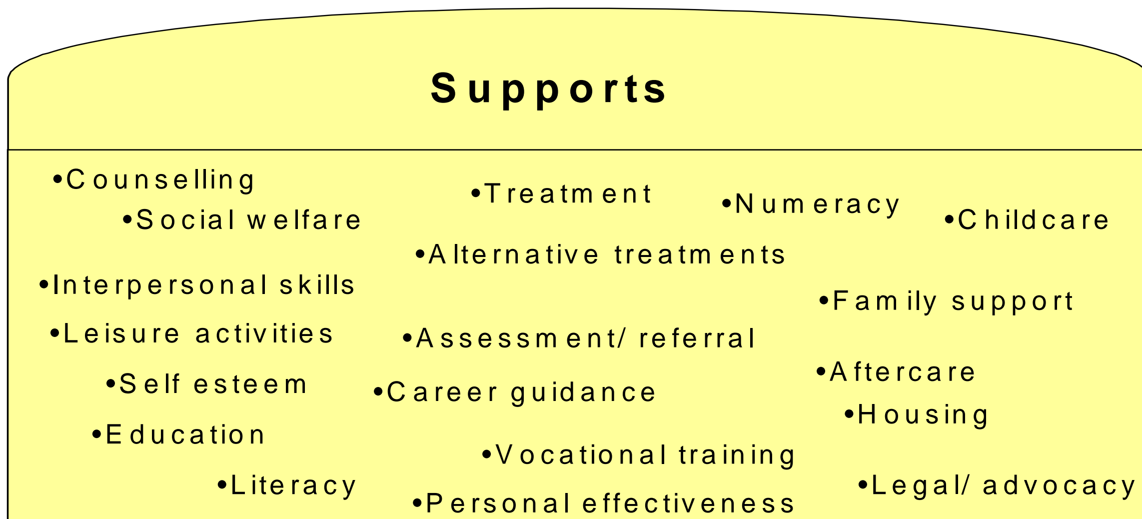


Figure 2

As indicated in Figure I, in the ***short-term***, the emphasis will be on stabilising the individual and ensuring that his or her basic needs are addressed. This will involve the provision of supports such as:

- Assessment and referral;
- Treatment;
- Counselling/ relapse prevention;
- Health and personal care (individuals will often have health issues, such as HIV and Hepatitis C, as a result of their drug use);
- Housing and social welfare issues;
- Legal/advocacy issues;
- Child welfare/childcare issues;
- Rebuilding family relationships;
- Personal development;
- Basic education/ training.

In the ***medium-term***, the emphasis will be on increasing personal/development skills, including:

- Confidence and self esteem;
- Personal development and effectiveness;
- Personal health (nutrition, hygiene, etc.);
- Education (literacy, numeracy, computer training, etc.);
- Vocational/job training (woodwork, metalwork, etc.);
- Short-term work experience (supervised);
- Effective parenting (assisting with homework, etc.);
- Leisure and cultural activities;
- Communication skills.

In the ***long-term***, the focus will shift to:

- Further education and lifelong learning;
- Career guidance and preparation for work;
- Work experience and training;
- Supporting the individual to re-enter the workforce;
- Life skills (consumer awareness, etc.);
- Leisure, cultural and other mainstream pursuits.

Again, the above represents a model progression path which in many instances simply will not be attainable. Factors - such as the individual's drug taking history, personal motivation, social skills, family situation, educational attainment, etc - will all affect the rate of progression. Accordingly, individuals will present with different needs, will enter the progression path at different points and will take different routes to recovery. Some supports, such as building self esteem and personal development, will transcend the entire period of rehabilitation. Others, such as education and training for work, will change as the individual develops and grows and perhaps uncovers latent talents or skills.

Accordingly, a considerable degree of flexibility is required and, ideally, an individual support and personal development plan should be available in each case.

4. Implementing an Individual Support and Development Plan

No single organisation has the range of competencies and expertise to cater for all needs identified in the previous section. Accordingly, they must be delivered through a number of bodies[1] (as indicated in Figure 3 below).

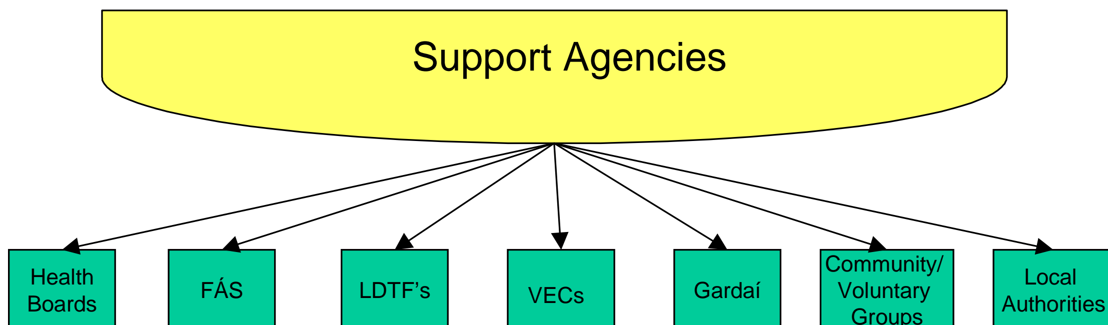


Figure 3

In any event, an integrated inter-agency response has significant advantages. It maximises the resources and expertise which are available across agencies. It allows drug users to access services on the same basis as other individuals. In this regard, drug users already have to contend with considerable stigmatisation, without it becoming a feature of State run rehabilitation programmes. An inter-agency approach also puts the client in contact with mainstream agencies and programmes from the outset, albeit in a sheltered environment (at least in the initial stages). This leaves open the option of their progressing to a point where they will be able to independently access mainstream services relative to their needs at a later date.

[1] Chapter 3 of the National Drugs Strategy 2001 – 2008 outlines in detail the range of activities agencies are involved in as part of an integrated response to drug misuse.

However, while an inter-agency response is widely accepted as the right approach and, indeed, underpins the whole National Drugs Strategy, it presents challenges, not least because the agencies involved continue to work through separate operational boundaries and planning processes. The key to the delivery of an integrated individual support and development plan, therefore, is to establish an appropriate entry point or gateway for the client and for the agencies to have sufficient flexibility to tailor their services to respond to the needs that are being identified.

5. Identifying an Appropriate Gateway

While an individual will need access to a range of supports to aid his or her rehabilitation, there is a need for a "gateway" support mechanism through which the client can access the various services required (as illustrated at Figure 4 below).

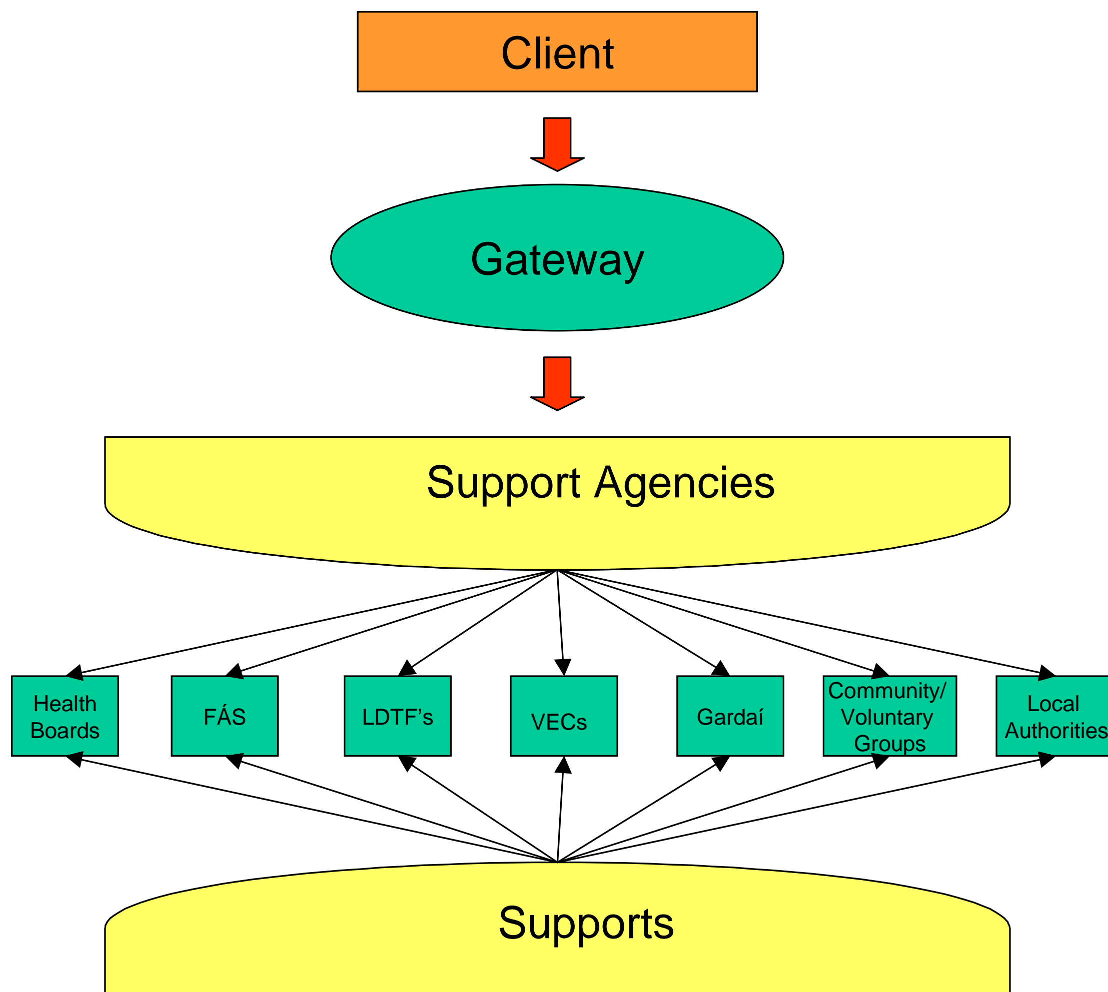


Figure 4

A number of key features would need to underpin such a "gateway" service, as follows:

It should be community based. While some clients can benefit from residential care, community-based rehabilitation programmes are particularly advantageous in terms of their accessibility to local people. Community-based programmes can be tailored to meet the

needs of particular areas or cohorts and that is why they feature prominently in a wide range of interventions to respond to drug misuse.

It should be flexible, both in terms of its structure and content. The programme should have a range of modules and be delivered in a manner which reflects the diverse needs of the client.

It should be able to link seamlessly into other "specialist" programmes. The programme must be able to "buy in" mainstream services, such as education, training, etc., which would be delivered in an appropriately sheltered environment.

It should be designed so as to allow a progression path into mainstream services as the client moves towards recovery. The hope is that, if properly motivated and supported, individuals will progress to a point where they will be able to access mainstream programmes independently. However, it must be remembered that depending on their circumstances, some individuals will need intensive supports over a long period. This is discussed further in section 8.

6. Role of Special CE Places

CE has been identified as a particularly suitable support mechanism through which drug rehabilitation programmes can be delivered for a number of reasons:

- It is community based, facilitating easy access to local people;
- It is flexible. It can be tailored to provide individual support and personal development plans to participants. Furthermore, its part-time nature is particularly suitable for individuals who are availing of treatment and other support services;
- Projects can act as advocates for participants around issues such as housing needs, social welfare, medical care, court cases, etc.;
- Project sponsors can link individuals into a range of services and supports. Education modules can be designed and delivered to cater specifically for the needs of the clients, with VEC tutors brought in to deliver specific modules. Addiction Counsellors provide support and relapse prevention modules;
- Participants can avail of mainstream FÁS programmes that are open to the general population, facilitating greater integration for the client into mainstream programmes.
- CE also affords an opportunity for clients to move on from services that are specifically drug focused. The location of CE within the broader context of work experience and placement provides an important stepping stone for people to move on to a wider range opportunities;
- The payment of an allowance, albeit a modest one, acts as an incentive which attracts clients into the programme. Without it, many individuals could not afford to participate;
- Locally based FÁS staff have a unique understanding of community-based training programmes and how they can be designed to suit local needs and circumstances. Through their work with drug projects, FÁS staff have developed a good knowledge and experience of local drug issues;
- The projects can present a positive message about the benefits of treatment, both for the individual and the wider community;
- The projects are devised and delivered by local community/ voluntary groups, thereby providing a mechanism through which these groups can make an important contribution to the response to drugs misuse in their areas.

The projects being supported under the initiative span all 3 phases of the progression path outlined at figure 1 and, in most instances, single projects operate in such a flexible manner that they cover all 3 phases. While the projects are primarily CE based, they are, as intimated previously, supported by a number of other agencies and programmes, representing an integrated, inter-agency (indeed inter-sectoral) approach.

Nevertheless, CE still needed to be adapted in order to meet the needs of an especially marginalised client group. Accordingly, some of the conditions normally attaching to the scheme were adjusted as it applied to the 1,000 special CE places for drug projects. There are outlined in figure 5 below.

Figure 5: Adjustments made to CE for drug projects

- Application and approval procedures were waived;
- Age pre-requisites were reduced from 25 to 18;
- Live register requirement was waived;
- Duration of programme was extended from 1 to 3 years;
- The participant/ supervisor ratio was reduced from 16:1 to 7:1;
- Participants retained special status, which meant they could transfer to another project;
- Training and Development Budgets were increased;
- A 25% worker element was included to allow local community workers assist with the delivery of the projects (thus providing training for local people);
- Certification to NCVA level 2 was included and supported.

7. How CE could be further enhanced as it applies to drugs projects

The Community and Voluntary Groups which have operated the drug rehabilitation projects over the last 5 years have found CE to be a particularly suitable support mechanism for the delivery of their projects. Notwithstanding this, these groups have identified a number of adjustments which they feel would further enhance its effectiveness. These are outlined at figure 6 below.

Figure 6: Proposals to Enhance CE as a Mechanism for the Delivery of Drug Projects

- Recent changes in the social welfare secondary benefits attaching to CE are making it difficult for clients to remain on programmes. As mentioned previously, recovering drug users are a particularly marginalised group, who need intensive supports if they are to progress towards re-integration into the mainstream. The CE allowance and secondary benefits very often represent their only means of support, as they attempt to complete the difficult rehabilitation process. Accordingly, the Department of Social and Family Affairs, in consultation with FÁS, should examine the restoration of these allowances;

- A disproportionately high number of clients have left school early and consequently their education and training needs can be very broad. While projects have already received additional training budgets to deliver the intensive level of supports required, these need to be further enhanced. FÁS, in conjunction with the Department of Education and Science, should examine how these additional training budgets might be financed, as well as setting appropriate standards and levels of accreditation which should apply to such training;

- The level of counselling available to individuals varies between projects. The relevant Health Boards, in consultation with FÁS, should examine this matter with a view to ensuring that an appropriate and standardised level of counselling is provided in all cases;

Continued overleaf…

- Some CE supervisors/ sponsors would benefit considerably from more in-depth training on issues surrounding drug misuse. The NDST, in conjunction with FÁS, will examine what training would be of assistance and how it should be provided.

8. Catering for Individuals who need Long-term Supports

Information available within FÁS can be collated and analysed to show the progression/success rates of individuals who have participated in the special CE projects. Based on the information available to us, we understand that the overall progression rates compare very favourably with other training programmes, both here in Ireland and abroad. By way of example, Appendix 1 illustrates how clients in one project in Dublin 12 progressed as a result of their involvement in a Special CE project.

Nevertheless, as has been re-iterated on a number of occasions throughout this submission, relapse and recidivism is very much a part of the rehabilitation process. Accordingly, not all individuals will progress through the special CE projects to independent living. Some individuals will need long-term, intensive supports and the question arises as to whether the special CE scheme can meet their particular needs.

The Health Boards are key players in the provision of treatment and other support services for drug users and they have been involved in the development of appropriate rehabilitation support models for individuals with long-term needs. Consideration should be given, therefore, to the development of mechanism where clients, who are identified as having special needs, are diverted on to specially adapted rehabilitation programmes rather than the CE scheme. However, pending the development and ready availability of suitable programmes, it would not be in the client's (or the community's) best interests to remove individuals from CE without having a more appropriate support service into which they could be diverted.

9. Conclusions

Arising from the foregoing, the following are the key conclusions:

- Drug misuse is a "cross-cutting" issue and no single agency has the range of competencies or expertise to provide all the supports needed to assist drug users to complete their rehabilitation. The response must involve an integrated, collaborative effort across a range of players (statutory, community and voluntary). This is the role which CE plays within an overall rehabilitation framework and is illustrated at Appendix 2.

- While CE was not designed as a drug rehabilitation programme, it has, as adapted at figure 5, proved to be a particularly effective mechanism through which a range of training and other supports can be delivered to recovering drug users, to enable them to move closer to re-integration and employment. Indeed, if it were to be replaced, any replacement programme would have to at least include all the key elements contained in the special CE scheme. Even then, it would be important not to lose the knowledge and expertise which FAS has acquired from its participation in this initiative. Notwithstanding its overall suitability, CE needs to be adapted further (see figure 6) in order to enhance its effectiveness.

- There is a need for further rehabilitation programmes, particularly ones which cater for individuals who require intensive, long-term support. The Health Boards will be key players in the development of such long-term supports, although the training

provided through CE will remain a crucial component. As the numbers accessing treatment continue to rise (from just under 2,000 when the CE initiative was introduced in 1997 to 6,423 this year), there is a need for a corresponding increase in rehabilitation places if drug users are to complete their recovery and progress to independent living.

Appendix 1 (example of a CE supported drug project)

The role of **Athrú**, which operates in the Dublin 12 LDTF area, is to **"**create and sustain a safe learning environment and education centre dedicated to the needs of people who are in recovery from drug misuse, by facilitating their growth from dependence to independence through the provision of accredited training and education"**.**

Athrú provides a **three year programme**, as set out below, but which remains flexible to meet the needs of each individual:

Year 1: focuses on stabilising the individual and preventing relapse by dealing primarily with the addiction through personal development and building confidence/self esteem. It introduces modules in numeracy and literacy, as well as leisure pursuits such as swimming, art and drama; **Year 2:** continues to focus on dealing with the addiction and prevention of relapse but broadens out the academic and vocational training modules and also incorporates classes on food and nutrition, anger management, consumer awareness, effective parenting skills, etc.; **Year 3:** focuses on taking practical steps to independence by doing preparation for work experience, CV development; liasing with training and employment agencies to assist the individuals to gain further formal skills and/or employment. The VEC assists the project directly in the provision of training.

Since September 1999, 35 individuals have participated in the Athrú programme. **Figure 1** below illustrates how participants have progressed since undertaking the programme. 40% of them moved to full time employment, 18% took up further education (1 to do the Leaving Certificate and 2 to do VEC courses); 6% have moved to the Local Employment Scheme (LES) and 18% left the course due to childcare/maternity issues and/or health reasons. There are a further sixteen individuals taking part in the current programme.

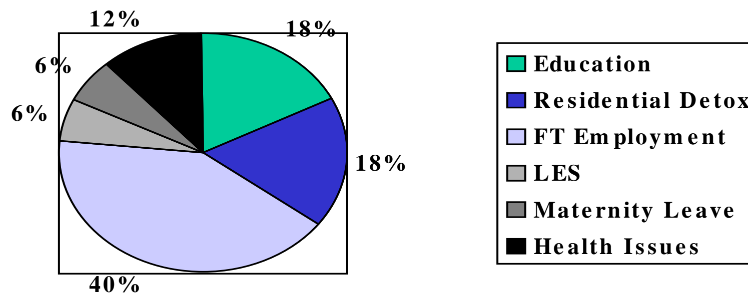


Figure 1

Athrú as a 'Gateway' to other Mainstream Supports

As can be seen from the **figure 2** below, the project has effectively acted as a 'gateway' to independent living at three levels:

- It acts as a launch pad to full time employment, with 40% of participants being able to achieve this goal following completion of the course;
- For those interested in pursuing further education and training, it introduces them to mainstream services such as the Department of Education, VECs and FAS (24%).
- For those dealing with relapse issues, the project can refer them to the appropriate residential detoxification programmes in the Health Board (18%).

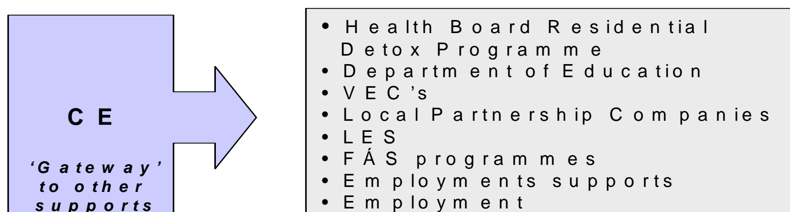
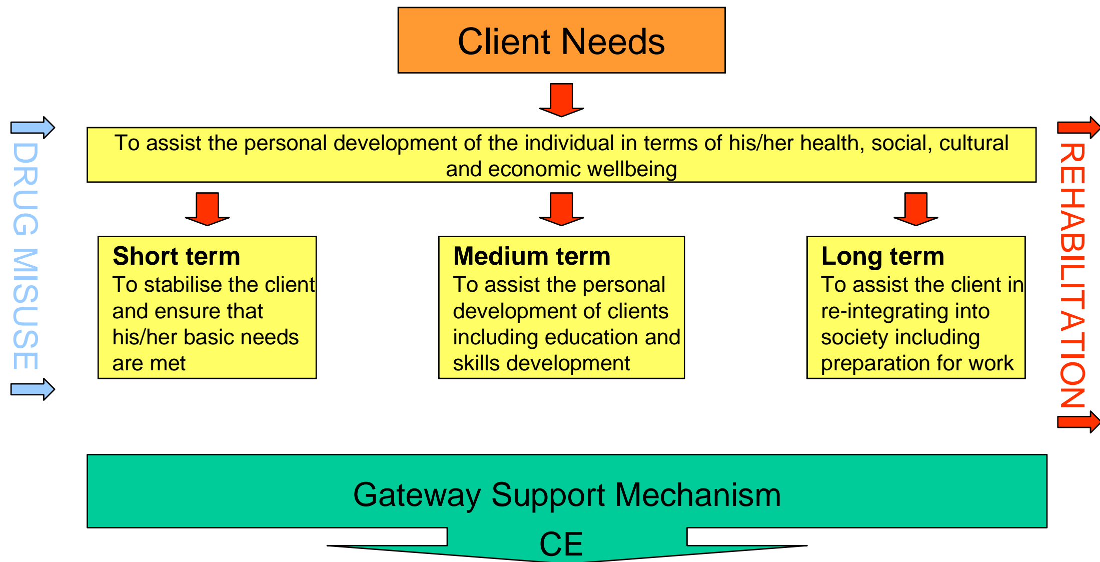
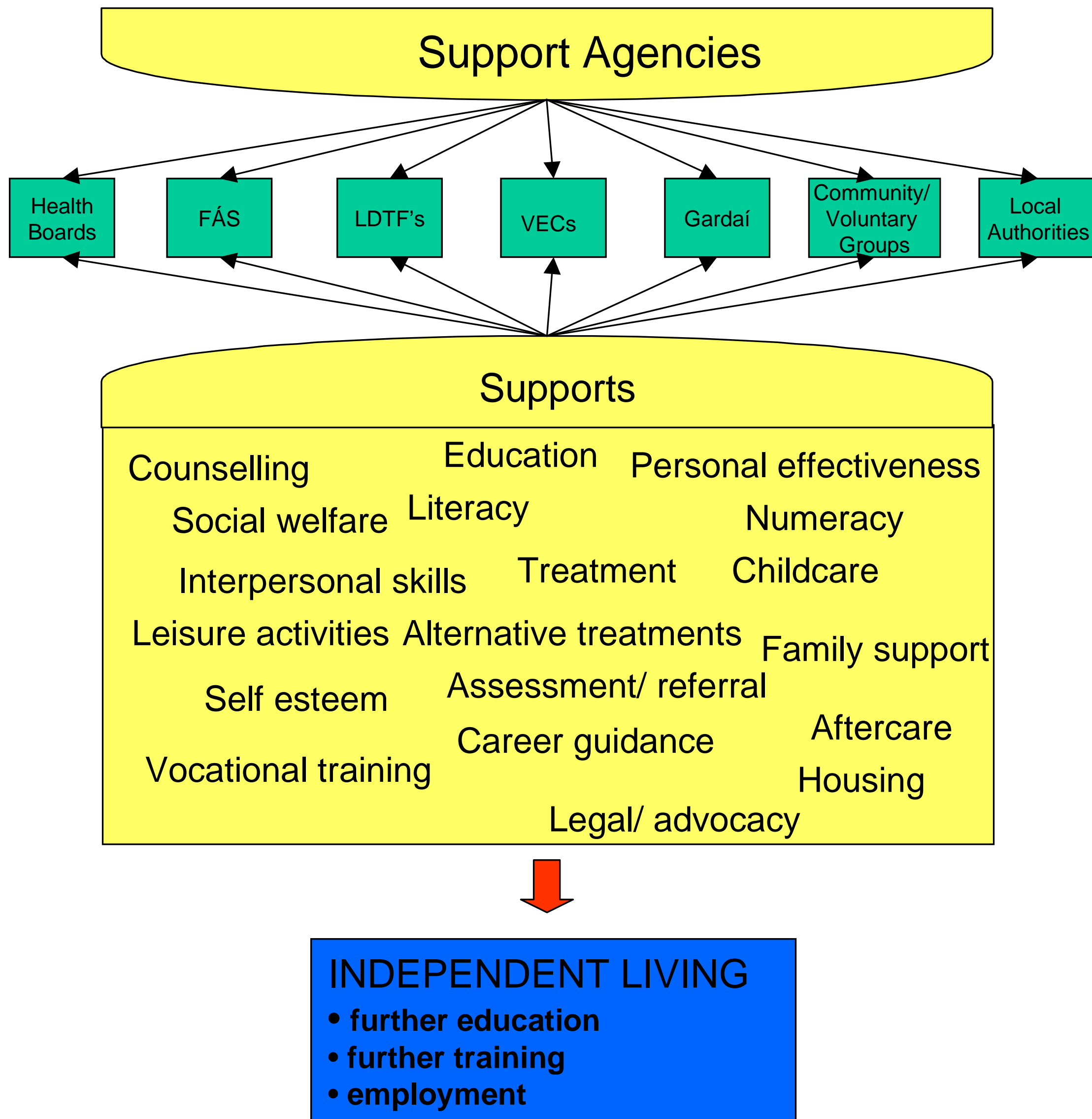


Figure 2

Appendix 2
PROGRESSION PATH TO REHABILITATION




Support Agencies
Health Boards
FÁS
LDTF's
VECs
Gardaí
Community/ Voluntary Groups
Local Authorities
Supports
Counselling
Education
Personal effectiveness
Social welfare
Literacy
Numeracy
Interpersonal skills
Treatment
Childcare
Leisure activities
Alternative treatments
Family support
Self esteem
Assessment/ referral
Aftercare
Career guidance
Vocational training
Housing
Legal/ advocacy
INDEPENDENT LIVING
• further education
• further training
• employment

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